

1 CRAIG B. GARNER (CA SBN 177971)  
2 GARNER HEALTH LAW CORPORATION  
3 13274 Fiji Way, Suite 250  
4 Marina Del Rey, CA 90292  
5 Telephone: (310) 458-1560  
6 Facsimile: (310) 694-9025  
7 Email: craig@garnerhealth.com

8 ROCHELLE J. BIOTEAU (CA SBN 228348)  
9 SQUIRES, SHERMAN & BIOTEAU, LLP  
10 1901 1<sup>ST</sup> Ave., Suite 415  
11 San Diego, CA 92101  
12 Telephone: (619) 696-8854  
13 Email: rochelle@ssblp.com

14 Attorneys for PLAINTIFF ABC SERVICES GROUP, INC., in its capacity as  
15 assignee for the benefit of creditors of MORNINGSIDE RECOVERY, LLC

16 UNITED STATES DISTRICT COURT  
17 CENTRAL DISTRICT OF CALIFORNIA, SOUTHERN DIVISION

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21 ABC SERVICES GROUP, INC., a  
22 Delaware corporation, in its capacity as  
23 assignee for the benefit of creditors of  
24 MORNINGSIDE RECOVERY, LLC, a  
25 California limited liability company,

26 Plaintiff,

27 v.

28 UNITED HEALTHCARE SERVICES,  
INC.; UNITED BEHAVIORAL  
HEALTH; OPTUM SERVICES, INC;  
USABLE MUTUAL INSURANCE  
COMPANY, doing business as

Lead Case No. 8:19-cv-00243-DOC-DFM

Hon. David O. Carter

**CONSOLIDATED AMENDED  
COMPLAINT FOR BREACH OF  
EMPLOYEE WELFARE BENEFIT  
PLAN (RECOVERY OF PLAN  
BENEFITS UNDER E.R.I.S.A.) 29  
U.S.C. § 1132(a)(1)(b)**

1 ARKANSAS BLUE CROSS AND  
2 BLUE SHIELD and BLUE CROSS  
3 AND BLUE SHIELD OF ARKANSAS  
4 BLUE ADVANTAGE; BLUE CROSS  
5 AND BLUE SHIELD OF KANSAS,  
6 INC.; BLUE CROSS AND BLUE  
7 SHIELD OF KANSAS CITY;  
8 HEALTH CARE SERVICE  
9 CORPORATION, doing business as  
10 BLUE CROSS AND BLUE SHIELD  
11 OF OKLAHOMA; BLUE CROSS  
12 AND BLUE SHIELD OF ALABAMA;  
13 ANTHEM BLUE CROSS LIFE AND  
14 HEALTH INSURANCE COMPANY;  
15 ANTHEM, INC., dba ANTHEM  
16 HEALTH, INC.; BLUE CROSS OF  
17 CALIFORNIA, INC.; HUMANA  
18 HEALTH PLAN OF CALIFORNIA,  
19 INC.; HUMANA BEHAVIORAL  
20 HEALTH, INC.; HUMANA  
21 INSURANCE COMPANY; HUMANA  
22 EMPLOYERS HEALTH PLAN OF  
23 GEORGIA, INC.; HUMANA, INC.;  
24 HUMANA HEALTH PLAN OF  
25 LOUISIANA, INC.; HUMANA  
26 HEALTH PLAN OF TEXAS, INC.;  
27 HUMANA MEDICAL PLAN; AETNA  
28 HEALTH AND LIFE INSURANCE  
COMPANY; BLUECROSS  
BLUESHIELD OF TENNESSEE,  
INC.; CIGNA HEALTHCARE OF  
CALIFORNIA, INC.; CIGNA  
BEHAVIORAL HEALTH OF  
CALIFORNIA, INC.; CIGNA  
HEALTH AND LIFE INSURANCE  
COMPANY; HMC HEALTHWORKS,  
LLC, fka HMC HEALTHWORKS,  
INC.; UNITED MEDICAL  
RESOURCES, INC.; SIERRA  
HEALTH AND LIFE INSURANCE  
COMPANY, INC.; MEDICAL  
MUTUAL OF OHIO; MEDICAL  
MUTUAL SERVICES, LLC; GROUP  
HEALTH PLAN, INC., doing business  
as HEALTHPARTNERS; MERITAIN  
HEALTH, INC.; BEACON HEALTH  
OPTIONS, INC.; BEACON HEALTH  
STRATEGIES, LLC;

1 VALUEOPTIONS OF CALIFORNIA,  
2 INC.; COVENTRY HEALTH CARE,  
3 INC.; MHNET SPECIALTY  
4 SERVICES, LLC; PROVIDENCE  
5 HEALTH PLAN; FIRST HEALTH  
6 INSURANCE CORPORATION; GHI,  
7 INC.,

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Defendants.

**CONSOLIDATED WITH:**

1. 8:19-cv-00531-DOC-DFM (*ABC Services Group, Inc. v. United Healthcare Services, Inc., et al.*)
2. 8:19-cv-00803-DOC-DFM (*ABC Services Group, Inc. v. USable Mutual Insurance Company, et al.*)
3. 8:19-cv-00776-DOC-DFM (*ABC Services Group, Inc. v. Health Care Service Corporation, et al.*)
4. 8:19-cv-00789-DOC-DFM (*ABC Services Group, Inc. v. Blue Cross and Blue Shield of Alabama, et al.*)
5. 8:19-cv-00677-DOC-DFM (*ABC Services Group, Inc. v. Anthem Blue Cross Life and Health Insurance Company, et al.*)
6. 8:20-cv-00175-DOC-DFM (*ABC Services Group, Inc. v. Humana Behavioral Health, Inc., et al.*)
7. 8:19-cv-00777-DOC-DFM (*ABC Services Group, Inc. v. Aetna Health and Life Insurance Company, et al.*)
8. 8:19-cv-00804-DOC-DFM (*ABC Services Group, Inc. v. Bluecross Blueshield of Tennessee, Inc., et al.*)
9. 8:19-cv-02125-DOC-DFM (*ABC Services Group, Inc. v. Cigna Healthcare of California, Inc., et al.*)
10. 8:19-cv-02136-DOC-DFM (*ABC Services Group, Inc. v. HMC Healthworks, Inc., et al.*)
11. 8:19-cv-02138-DOC-DFM (*ABC Services Group, Inc. v. United Medical Resources, Inc., et al.*)
12. 8:19-cv-02168-DOC-DFM (*ABC Services Group, Inc. v. Sierra Health and Life Insurance Company, Inc., et al.*)
13. 8:19-cv-02122-DOC-DFM (*ABC Services Group, Inc. v. Medical Mutual of Ohio, et al.*)

- 1 **14.** 8:19-cv-02242-DOC-DFM (*ABC Services Group, Inc. v. Group Health Plan,*  
2 *Inc., et al.*)
- 3 **15.** 8:19-cv-02182-DOC-DFM (*ABC Services Group, Inc. v. Meritain Health,*  
4 *Inc., et al.*)
- 5 **16.** 8:19-cv-02204-DOC-DFM (*ABC Services Group, Inc. v. Beacon Health*  
6 *Options, Inc., et al.*)
- 7 **17.** 8:19-cv-02131-DOC-DFM (*ABC Services Group, Inc. v. Coventry Health*  
8 *Care, Inc., et al.* [previously 8:19-cv-09432-DOC-DFM])
- 9 **18.** 8:19-cv-02219-DOC-DFM (*ABC Services Group, Inc. v. MHNet Specialty*  
10 *Services, LLC., et al.*)
- 11 **19.** 8:19-cv-02172-DOC-DFM (*ABC Services Group, Inc. v. Providence Health*  
12 *Plan, et al.*)
- 13 **20.** 8:19-cv-02171-DOC-DFM (*ABC Services Group, Inc. v. First Health Group*  
14 *Corporation, et al.*)
- 15 **21.** 8:19-cv-02129-DOC-DFM (*ABC Services Group, Inc. v GHI, Inc., et al.*)<sup>1</sup>  
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28 <sup>1</sup> The Clerk of the Court entered the default against defendant GHI, Inc.,  
the only named defendant in Case No. 8:19-cv-02129 (ECF No. 343).

1 Pursuant to the February 14, 2022, Order of this Court (ECF No. 586), ABC  
2 SERVICES GROUP, INC., a Delaware corporation (“**ABC**” or “**Plaintiff**”), in its  
3 capacity as assignee for the benefit of creditors of MORNINGSIDE RECOVERY,  
4 LLC, a California limited liability company (“**Morningside**”) complains and alleges  
5 in this Consolidated Amended Complaint (“**Complaint**”) against Defendants United  
6 Healthcare Services, Inc, United Behavioral Health and Optum Services, Inc.  
7 [original filing 8:19-cv-00531-DOC-DFM], USABLE Mutual Insurance Company,  
8 dba Arkansas Blue Cross and Blue Shield and as Blue Advantage Administrators of  
9 Arkansas, Blue Cross and Blue Shield of Kansas City, Blue Cross and Blue Shield  
10 of Kansas, Inc. and Blue Cross & Blue Shield of Mississippi, A Mutual Insurance  
11 Company [original filing 8:19-cv-00803-DOC-DFM], Health Care Service  
12 Corporation, a Mutual Legal Reserve Company, dba Blue Cross and Blue Shield of  
13 Oklahoma [original filing 8:19-cv-00776-DOC-DFM], Blue Cross and Blue Shield  
14 of Alabama [original filing 8:19-cv-00789-DOC-DFM], Anthem Blue Cross Life  
15 and Health Insurance Company, Anthem, Inc., Anthem, Inc. dba Anthem Health,  
16 Inc., The Anthem Companies of California, Inc. and The Anthem Companies, Inc.  
17 (together, “Anthem”) [original filing 8:19-cv-00677-DOC-DFM], Humana  
18 Insurance Company, Humana Employers Health Plan of Georgia, Inc., Humana  
19 Behavioral Health, Inc., Humana Health Plan of California, Inc., Humana Inc.,  
20 Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Texas, Inc.,  
21 Humana Health Plan, Inc., and Humana Medical Plan (erroneously sued as Humana  
22 Insurance Company and Humana Medical Plan) [original filing 8:19-cv-00317-  
23 DOC-DFM], Aetna Health and Life Insurance Company [original filing 8:19-cv-  
24 00777-DOC-DFM], Bluecross Blueshield of Tennessee, Inc. [original filing 8:19-  
25 cv-00804-DOC-DFM], ComPsych Corporation [original filing 8:19-cv-02123-  
26 DOC-DFM], Cigna HealthCare of California, Inc., Cigna Behavioral Health of  
27 California, Inc., and Cigna Health and Life Insurance Company [original filing 8:19-  
28 cv-02125-DOC-DFM], HMC Healthworks, Inc., now known as HMC Healthworks,

1 LLC [original filing 8:19-cv-02136-DOC-DFM], United Medical Resources, Inc.  
2 [original filing 8:19-cv-02138-DOC-DFM], Sierra Health and Life Insurance  
3 Company, Inc. [original filing 8:19-cv-02168-DOC-DFM], Medical Mutual of Ohio  
4 and Medical Mutual Services, LLC [original filing 8:19-cv-02122-DOC-DFM],  
5 Group Health Plan, Inc., dba Healthpartners [original filing 8:19-cv-02242-DOC-  
6 DFM], Meritain Health, Inc. [original filing 8:19-cv-02182-DOC-DFM], Beacon  
7 Health Options, Inc., Beacon Health Strategies, LLC, Valueoptions Federal  
8 Services, Inc. and Valueoptions of California, Inc. (together, “Beacon”) [original  
9 filing 8:19-cv-02204-DOC-DFM], Coventry Health Care, Inc. [original filing 8:19-  
10 cv-02131-DOC-DFM (previously 8:19-cv-09432-DOC-DFM)], MHNet Specialty  
11 Services, LLC [original filing 8:19-cv-02219-DOC-DFM], Providence Health Plan  
12 [original filing 8:19-cv-02172-DOC-DFM], First Health Group Corporation  
13 [original filing 8:19-cv-02171-DOC-DFM] and GHI, Inc. [original filing 8:19-cv-  
14 02129-DOC-DFM]<sup>2</sup> (collectively the “**Consolidated Defendants**” or  
15 “**Defendants**”) as follows:

### 16 **THE PARTIES**

17 **1.** ABC is a corporation organized and existing under the laws of the State  
18 of Delaware, with its primary place of business located in Santa Ana, California.

19 **2.** Morningside, at all relevant times, provided professional medical and  
20 mental health services and rehabilitation care for patients suffering from mental  
21 health and substance use disorders (“**SUDs**”) from its location in Irvine, California.

22 **3.** Defendant UNITED HEALTHCARE SERVICES, INC. is, and at all  
23 relevant times was a Minnesota corporation licensed to do business in and is and  
24 was doing business in the State of California as a provider of health insurance  
25 benefits. Plaintiff is informed and believes, and based thereon alleges, that  
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27 <sup>2</sup> The Clerk of the Court entered the default against defendant GHI, Inc.,  
28 the only named defendant in Case No. 8:19-cv-02129 (ECF No. 343), and counsel  
for Plaintiff is unaware of any representation on behalf of GHI, Inc. at this time.

1 UNITED HEALTHCARE SERVICES, INC. is licensed by the California  
2 Department of Insurance and/or the California Department of Managed Health Care  
3 to transact business of insurance in the State of California, is in fact transacting the  
4 business of insurance in the State of California and is thereby subject to the laws  
5 and regulations of the State of California.

6 4. Defendant UNITED BEHAVIORAL HEALTH is, and at all relevant  
7 times was a California corporation licensed to do business in and is and was doing  
8 business in the State of California as a provider of health insurance benefits.

9 Plaintiff is informed and believes, and based thereon alleges, that UNITED  
10 BEHAVIORAL HEALTH is licensed by the California Department of Insurance  
11 and/or the California Department of Managed Health Care to transact business of  
12 insurance in the State of California, is in fact transacting the business of insurance  
13 in the State of California and is thereby subject to the laws and regulations of the  
14 State of California

15 5. Defendant OPTUM SERVICES, INC. is, and at all relevant times was  
16 a Delaware corporation licensed to do business in and is and was doing business in  
17 the State of California as a provider of health insurance benefits. Plaintiff is  
18 informed and believes, and based thereon alleges, that OPTUM SERVICES, INC.  
19 is licensed by the California Department of Insurance and/or the California  
20 Department of Managed Health Care to transact business of insurance in the State  
21 of California, is in fact transacting the business of insurance in the State of  
22 California and is thereby subject to the laws and regulations of the State of  
23 California

24 6. Defendant USABLE MUTUAL INSURANCE COMPANY, doing  
25 business as ARKANSAS BLUE CROSS AND BLUE SHIELD as well as BLUE  
26 CROSS AND BLUE SHIELD OF ARKANSAS TRUE ADVANTAGE is, and at  
27 all relevant times was an Arkansas corporation licensed to do business in and is and  
28 was doing business in the State of California as a provider of health insurance



1 benefits. Plaintiff is informed and believes, and based thereon alleges, that  
2 USABLE MUTUAL INSURANCE COMPANY is licensed by the California  
3 Department of Insurance and/or the California Department of Managed Health Care  
4 to transact business of insurance in the State of California, is in fact transacting the  
5 business of insurance in the State of California and is thereby subject to the laws  
6 and regulations of the State of California.

7       **7.** Defendant BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.  
8 is, and at all relevant times was a Kansas corporation licensed to do business in and  
9 is and was doing business in the State of California as a provider of health  
10 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
11 that BLUE CROSS AND BLUE SHIELD OF KANSAS, INC. is licensed by the  
12 California Department of Insurance and/or the California Department of Managed  
13 Health Care to transact business of insurance in the State of California, is in fact  
14 transacting the business of insurance in the State of California and is thereby  
15 subject to the laws and regulations of the State of California.

16       **8.** Defendant BLUE CROSS AND BLUE SHIELD OF KANSAS CITY  
17 is, and at all relevant times was a Missouri corporation licensed to do business in  
18 and is and was doing business in the State of California as a provider of health  
19 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
20 BLUE CROSS AND BLUE SHIELD OF KANSAS CITY is licensed by the  
21 California Department of Insurance and/or the California Department of Managed  
22 Health Care to transact business of insurance in the State of California, is in fact  
23 transacting the business of insurance in the State of California and is thereby  
24 subject to the laws and regulations of the State of California.

25       **9.** Defendant HEALTH CARE SERVICE CORPORATION, doing  
26 business as BLUE CROSS AND BLUE SHIELD OF OKLAHOMA is, and at all  
27 relevant times was an Oklahoma corporation licensed to do business in and is and  
28 was doing business in the State of California as a provider of health insurance

1 benefits. Plaintiff is informed and believes, and based thereon alleges, that  
2 HEALTH CARE SERVICE CORPORATION is licensed by the California  
3 Department of Insurance and/or the California Department of Managed Health Care  
4 to transact business of insurance in the State of California, is in fact transacting the  
5 business of insurance in the State of California and is thereby subject to the laws  
6 and regulations of the State of California.

7 **10.** Defendant BLUE CROSS AND BLUE SHIELD OF ALABAMA is,  
8 and at all relevant times was an Alabama corporation licensed to do business in and  
9 is and was doing business in the State of California as a provider of health  
10 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
11 that BLUE CROSS AND BLUE SHIELD OF ALABAMA is licensed by the  
12 California Department of Insurance and/or the California Department of Managed  
13 Health Care to transact business of insurance in the State of California, is in fact  
14 transacting the business of insurance in the State of California and is thereby  
15 subject to the laws and regulations of the State of California

16 **11.** Defendant ANTHEM BLUE CROSS LIFE AND HEALTH  
17 INSURANCE COMPANY is, and at all relevant times was a California corporation  
18 licensed to do business in and is and was doing business in the State of California  
19 as a provider of health insurance benefits. Plaintiff is informed and believes, and  
20 based thereon alleges, that ANTHEM BLUE CROSS LIFE AND HEALTH  
21 INSURANCE COMPANY is licensed by the California Department of Insurance  
22 and/or the California Department of Managed Health Care to transact business of  
23 insurance in the State of California, is in fact transacting the business of insurance  
24 in the State of California and is thereby subject to the laws and regulations of the  
25 State of California.

26 **12.** Defendant ANTHEM, INC., dba ANTHEM HEALTH, INC. is, and at  
27 all relevant times was an Indiana corporation licensed to do business in and is and  
28 was doing business in the State of California as a provider of health insurance

1 benefits. Plaintiff is informed and believes, and based thereon alleges, that  
2 ANTHEM INC. is licensed by the California Department of Insurance and/or the  
3 California Department of Managed Health Care to transact business of insurance in  
4 the State of California, is in fact transacting the business of insurance in the State of  
5 California and is thereby subject to the laws and regulations of the State of  
6 California.

7 **13.** Defendant BLUE CROSS OF CALIFORNIA, INC. is, and at all  
8 relevant times was a California corporation licensed to do business in and is and  
9 was doing business in the State of California as a provider of health insurance  
10 benefits. Plaintiff is informed and believes, and based thereon alleges, that BLUE  
11 CROSS OF CALIFORNIA, INC. is licensed by the California Department of  
12 Insurance and/or the California Department of Managed Health Care to transact  
13 business of insurance in the State of California, is in fact transacting the business of  
14 insurance in the State of California and is thereby subject to the laws and  
15 regulations of the State of California.

16 **14.** Defendant HUMANA HEALTH PLAN OF CALIFORNIA, INC. is,  
17 and at all relevant times was a California corporation licensed to do business in and  
18 is and was doing business in the State of California as a provider of health  
19 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
20 that HUMANA HEALTH PLAN OF CALIFORNIA, INC. is licensed by the  
21 California Department of Insurance and/or the California Department of Managed  
22 Health Care to transact business of insurance in the State of California, is in fact  
23 transacting the business of insurance in the State of California and is thereby  
24 subject to the laws and regulations of the State of California.

25 **15.** Defendant HUMANA BEHAVIORAL HEALTH, INC. is, and at all  
26 relevant times was a Texas corporation licensed to do business in and is and was  
27 doing business in the State of California as a provider of health insurance benefits.  
28 Plaintiff is informed and believes, and based thereon alleges, that HUMANA

1 BEHAVIORAL HEALTH, INC. is licensed by the California Department of  
2 Insurance and/or the California Department of Managed Health Care to transact  
3 business of insurance in the State of California, is in fact transacting the business of  
4 insurance in the State of California and is thereby subject to the laws and  
5 regulations of the State of California.

6 **16.** Defendant HUMANA, INC. is, and at all relevant times was a  
7 Delaware corporation licensed to do business in and is and was doing business in  
8 the State of California as a provider of health insurance benefits. Plaintiff is  
9 informed and believes, and based thereon alleges, that HUMANA, INC. is licensed  
10 by the California Department of Insurance and/or the California Department of  
11 Managed Health Care to transact business of insurance in the State of California, is  
12 in fact transacting the business of insurance in the State of California and is thereby  
13 subject to the laws and regulations of the State of California

14 **17.** Defendant HUMANA INSURANCE COMPANY is, and at all relevant  
15 times was a Wisconsin corporation licensed to do business in and is and was doing  
16 business in the State of California as a provider of health insurance benefits.  
17 Plaintiff is informed and believes, and based thereon alleges, that HUMANA  
18 INSURANCE COMPANY is licensed by the California Department of Insurance  
19 and/or the California Department of Managed Health Care to transact business of  
20 insurance in the State of California, is in fact transacting the business of insurance  
21 in the State of California and is thereby subject to the laws and regulations of the  
22 State of California.

23 **18.** Defendant HUMANA HEALTH BENEFIT PLAN OF LOUISIANA is,  
24 and at all relevant times was a Louisiana corporation licensed to do business in and  
25 is and was doing business in the State of California as a provider of health  
26 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
27 that HUMANA HEALTH BENEFIT PLAN OF LOUISIANA is licensed by the  
28 California Department of Insurance and/or the California Department of Managed

1 Health Care to transact business of insurance in the State of California, is in fact  
2 transacting the business of insurance in the State of California and is thereby  
3 subject to the laws and regulations of the State of California.

4 **19.** Defendant HUMANA HEALTH PLAN OF TEXAS, INC., is, and at  
5 all relevant times was a Texas corporation licensed to do business in and is and was  
6 doing business in the State of California as a provider of health insurance benefits.  
7 Plaintiff is informed and believes, and based thereon alleges, that HUMANA  
8 HEALTH PLAN OF TEXAS, INC. is licensed by the California Department of  
9 Insurance and/or the California Department of Managed Health Care to transact  
10 business of insurance in the State of California, is in fact transacting the business of  
11 insurance in the State of California and is thereby subject to the laws and  
12 regulations of the State of California

13 **20.** Defendant AETNA HEALTH AND LIFE INSURANCE COMPANY  
14 is, and at all relevant times was a Connecticut corporation licensed to do business  
15 in and is and was doing business in the State of California as a provider of health  
16 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
17 that AETNA HEALTH AND LIFE INSURANCE COMPANY is licensed by the  
18 California Department of Insurance and/or the California Department of Managed  
19 Health Care to transact business of insurance in the State of California, is in fact  
20 transacting the business of insurance in the State of California and is thereby  
21 subject to the laws and regulations of the State of California.

22 **21.** Defendant BLUECROSS BLUESHIELD OF TENNESSEE, INC. is,  
23 and at all relevant times was an Tennessee corporation licensed to do business in  
24 and is and was doing business in the State of California as a provider of health  
25 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
26 that BLUECROSS BLUESHIELD OF TENNESSEE, INC. is licensed by the  
27 California Department of Insurance and/or the California Department of Managed  
28 Health Care to transact business of insurance in the State of California, is in fact

1 transacting the business of insurance in the State of California and is thereby  
2 subject to the laws and regulations of the State of California.

3 **22.** Defendant CIGNA HEALTHCARE OF CALIFORNIA, INC. is, and at  
4 all relevant times was a California corporation licensed to do business in and is and  
5 was doing business in the State of California as a provider of health insurance  
6 benefits. Plaintiff is informed and believes, and based thereon alleges, that CIGNA  
7 HEALTHCARE OF CALIFORNIA, INC. is licensed by the California Department  
8 of Insurance and/or the California Department of Managed Health Care to transact  
9 business of insurance in the State of California, is in fact transacting the business of  
10 insurance in the State of California and is thereby subject to the laws and  
11 regulations of the State of California.

12 **23.** Defendant CIGNA BEHAVIORAL HEALTH OF CALIFORNIA,  
13 INC. is, and at all relevant times was a California corporation licensed to do  
14 business in and is and was doing business in the State of California as a provider of  
15 health insurance benefits. Plaintiff is informed and believes, and based thereon  
16 alleges, that CIGNA BEHAVIORAL HEALTH OF CALIFORNIA, INC. is  
17 licensed by the California Department of Insurance and/or the California  
18 Department of Managed Health Care to transact business of insurance in the State  
19 of California, is in fact transacting the business of insurance in the State of  
20 California and is thereby subject to the laws and regulations of the State of  
21 California

22 **24.** Defendant CIGNA HEALTH AND LIFE INSURANCE COMPANY  
23 is, and at all relevant times was a Connecticut corporation licensed to do business  
24 in and is and was doing business in the State of California as a provider of health  
25 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
26 that CIGNA HEALTH AND LIFE INSURANCE COMPANY is licensed by the  
27 California Department of Insurance and/or the California Department of Managed  
28 Health Care to transact business of insurance in the State of California, is in fact

1 transacting the business of insurance in the State of California and is thereby  
2 subject to the laws and regulations of the State of California.

3 **25.** Defendant HMC HEALTHWORKS, LLC (fka HMC Healthworks,  
4 Inc.). is, and at all relevant times was a Florida limited liability company licensed  
5 to do business in and is and was doing business in the State of California as a  
6 provider of health insurance benefits. Plaintiff is informed and believes, and based  
7 thereon alleges, that HMC Healthworks, LLC. is licensed by the California  
8 Department of Insurance and/or the California Department of Managed Health Care  
9 to transact business of insurance in the State of California, is in fact transacting the  
10 business of insurance in the State of California and is thereby subject to the laws  
11 and regulations of the State of California.

12 **26.** Defendant UNITED MEDICAL RESOURCES, INC. is, and at all  
13 relevant times was a California corporation licensed to do business in and is and  
14 was doing business in the State of California as a provider of health insurance  
15 benefits. Plaintiff is informed and believes, and based thereon alleges, that  
16 UNITED MEDICAL RESOURCES, INC. is licensed by the California Department  
17 of Insurance and/or the California Department of Managed Health Care to transact  
18 business of insurance in the State of California, is in fact transacting the business of  
19 insurance in the State of California and is thereby subject to the laws and  
20 regulations of the State of California.

21 **27.** Defendant SIERRA HEALTH AND LIFE INSURANCE COMPANY,  
22 INC. is, and at all relevant times was a Nevada corporation licensed to do business  
23 in and is and was doing business in the State of California as a provider of health  
24 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
25 that SIERRA HEALTH AND LIFE INSURANCE COMPANY is licensed by the  
26 California Department of Insurance and/or the California Department of Managed  
27 Health Care to transact business of insurance in the State of California, is in fact  
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1 transacting the business of insurance in the State of California and is thereby  
2 subject to the laws and regulations of the State of California.

3 **28.** Defendant MEDICAL MUTUAL OF OHIO is, and at all relevant times  
4 was an Ohio corporation licensed to do business in and is and was doing business  
5 in the State of California as a provider of health insurance benefits. Plaintiff is  
6 informed and believes, and based thereon alleges, that MEDICAL MUTUAL OF  
7 OHIO is licensed by the California Department of Insurance and/or the California  
8 Department of Managed Health Care to transact business of insurance in the State  
9 of California, is in fact transacting the business of insurance in the State of  
10 California and is thereby subject to the laws and regulations of the State of  
11 California.

12 **29.** Defendant MEDICAL MUTUAL SERVICES, LLC is, and at all  
13 relevant times was an OHIO limited liability company licensed to do business in  
14 and is and was doing business in the State of California as a provider of health  
15 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
16 that MEDICAL MUTUAL SERVICES, LLC is licensed by the California  
17 Department of Insurance and/or the California Department of Managed Health Care  
18 to transact business of insurance in the State of California, is in fact transacting the  
19 business of insurance in the State of California and is thereby subject to the laws  
20 and regulations of the State of California.

21 **30.** Defendant GROUP HEALTH PLAN, INC., doing business as  
22 HEALTHPARTNERS is, and at all relevant times was a Minnesota corporation  
23 licensed to do business in and is and was doing business in the State of California  
24 as a provider of health insurance benefits. Plaintiff is informed and believes, and  
25 based thereon alleges, that GROUP HEALTH PLAN, INC. is licensed by the  
26 California Department of Insurance and/or the California Department of Managed  
27 Health Care to transact business of insurance in the State of California, is in fact  
28



1 transacting the business of insurance in the State of California and is thereby  
2 subject to the laws and regulations of the State of California.

3 **31.** Defendant MERITAIN HEALTH, INC. is, and at all relevant times was  
4 a New York corporation licensed to do business in and is and was doing business in  
5 the State of California as a provider of health insurance benefits. Plaintiff is  
6 informed and believes, and based thereon alleges, that MERITAIN HEALTH, INC.  
7 is licensed by the California Department of Insurance and/or the California  
8 Department of Managed Health Care to transact business of insurance in the State  
9 of California, is in fact transacting the business of insurance in the State of  
10 California and is thereby subject to the laws and regulations of the State of  
11 California.

12 **32.** Defendant BEACON HEALTH OPTIONS, INC. is, and at all relevant  
13 times was a Virginia corporation licensed to do business in and is and was doing  
14 business in the State of California as a provider of health insurance benefits.  
15 Plaintiff is informed and believes, and based thereon alleges, that BEACON  
16 HEALTH OPTIONS, INC. is licensed by the California Department of Insurance  
17 and/or the California Department of Managed Health Care to transact business of  
18 insurance in the State of California, is in fact transacting the business of insurance  
19 in the State of California and is thereby subject to the laws and regulations of the  
20 State of California.

21 **33.** Defendant BEACON HEALTH STRATEGIES, LLC is, and at all  
22 relevant times was a Massachusetts limited liability company licensed to do  
23 business in and is and was doing business in the State of California as a provider of  
24 health insurance benefits. Plaintiff is informed and believes, and based thereon  
25 alleges, that BEACON HEALTH STRATEGIES, LLC is licensed by the California  
26 Department of Insurance and/or the California Department of Managed Health Care  
27 to transact business of insurance in the State of California, is in fact transacting the  
28

1 business of insurance in the State of California and is thereby subject to the laws  
2 and regulations of the State of California.

3 **34.** Defendant VALUEOPTIONS OF CALIFORNIA, INC. is, and at all  
4 relevant times was a California corporation licensed to do business in and is and  
5 was doing business in the State of California as a provider of health insurance  
6 benefits. Plaintiff is informed and believes, and based thereon alleges, that  
7 VALUE OPTIONS OF CALIFORNIA, INC. is licensed by the California  
8 Department of Insurance and/or the California Department of Managed Health Care  
9 to transact business of insurance in the State of California, is in fact transacting the  
10 business of insurance in the State of California and is thereby subject to the laws  
11 and regulations of the State of California.

12 **35.** Defendant COVENTRY HEALTH CARE, INC. is, and at all relevant  
13 times was a Pennsylvania and Connecticut corporation licensed to do business in  
14 and is and was doing business in the State of California as a provider of health  
15 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
16 that COVENTRY HEALTH CARE, INC. is licensed by the California Department  
17 of Insurance and/or the California Department of Managed Health Care to transact  
18 business of insurance in the State of California, is in fact transacting the business of  
19 insurance in the State of California and is thereby subject to the laws and  
20 regulations of the State of California.

21 **36.** Defendant MHNET SPECIALTY SERVICES, LLC is, and at all  
22 relevant times was a Maryland limited liability company, licensed to do business in  
23 and is and was doing business in the State of California as a provider of health  
24 insurance benefits. Plaintiff is informed and believes, and based thereon alleges,  
25 that MHNET SPECIALTY SERVICES, LLC is licensed by the California  
26 Department of Insurance and/or the California Department of Managed Health Care  
27 to transact business of insurance in the State of California, is in fact transacting the  
28

1 business of insurance in the State of California and is thereby subject to the laws  
2 and regulations of the State of California.

3 **37.** Defendant PROVIDENCE HEALTH PLAN is, and at all relevant  
4 times was an Oregon public benefit corporation licensed to do business in and is  
5 and was doing business in the State of California as a provider of health insurance  
6 benefits. Plaintiff is informed and believes, and based thereon alleges, that  
7 PROVIDENCE HEALTH PLAN is licensed by the California Department of  
8 Insurance and/or the California Department of Managed Health Care to transact  
9 business of insurance in the State of California, is in fact transacting the business of  
10 insurance in the State of California and is thereby subject to the laws and  
11 regulations of the State of California.

12 **38.** Defendant FIRST HEALTH INSURANCE CORPORATION is, and at  
13 all relevant times was a Delaware corporation licensed to do business in and is and  
14 was doing business in the State of California as a provider of health insurance  
15 benefits. Plaintiff is informed and believes, and based thereon alleges, that FIRST  
16 HEALTH INSURANCE COMPANY is licensed by the California Department of  
17 Insurance and/or the California Department of Managed Health Care to transact  
18 business of insurance in the State of California, is in fact transacting the business of  
19 insurance in the State of California and is thereby subject to the laws and  
20 regulations of the State of California.

### 21 **STANDING**

22 **39.** The text of the Employee Retirement Income Security Act of 1974  
23 (“**ERISA**”) authorizes a “participant or beneficiary” of an ERISA plan to bring a  
24 civil action. The law of the Ninth Circuit holds that health care providers are not  
25 “beneficiaries” within the meaning of ERISA. *See DB Healthcare, LLC*, 852 F.3d  
26 at 874. Therefore, “a non-participant health care provider . . . cannot bring claims  
27 for benefits on its own behalf. It must do so derivatively, relying on its patients’  
28

1 assignments of their benefits claims.” *Spinedex Physical Therapy USA Inc. v.*  
2 *United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1289 (9th Cir. 2014).

3 **40.** It is well-established in the Ninth Circuit that assignees are generally  
4 allowed to bring suit on behalf of the assignor. *See Spring Commc’ns Co., L.P. v.*  
5 *APCC Servs.*, 554 U.S. 269, 275 (2008) (“[H]istory and precedent are clear on the  
6 question before us: Assignees of a claim, including assignees for collection, have  
7 long been permitted to bring suit,” This general principle extends into the ERISA  
8 context. *See Misic v. Bldg. Serv. Emps. Health & Welfare Tr.*, 789 F.2d 1374, 1378  
9 (9<sup>th</sup> Cir. 1986); *Spinedex*, 770 F.3d at 1288.

10 **41.** The Ninth Circuit historically set certain limits to derivative standing,  
11 and specifically refused to extend derivative standing in *Simon v. Value Behav.*  
12 *Health, Inc.*, 208 F.3d 1073, 1080 (9<sup>th</sup> Cir. 2000), *amended by* 234 F.3d 428 (9<sup>th</sup>  
13 Cir. 2000), and *overruled on other grounds by Odom v. Microsoft Corp.*, 486 F.3d  
14 541 (9<sup>th</sup> Cir. 2007) (expressing concern that expanding derivative standing to  
15 someone like Simon would “be tantamount to transforming health benefit claims  
16 into a freely tradable commodity”).

17 **42.** Most recently, however, the Ninth Circuit clarified the limitations to  
18 derivative standing set forth in *Simon*, and in *Bristol SL Holdings, Inc. v. Cigna*  
19 *Health and Life Ins. Co.*, No. 20-56122 \_\_\_ F.4th\_\_\_ (9th Cir. Jan. 14, 2022), the  
20 Ninth Circuit held that as a bankruptcy successor-in-interest to the provider, the  
21 plaintiff in *Bristol* fit “comfortably within our circuit’s existing case law. . . .  
22 Refusing to allow derivative standing in this unique circumstance would create  
23 serious perverse incentives that would undermine the goal of ERISA. Without the  
24 type of derivative standing claimed by Bristol . . . Cigna could force healthcare  
25 providers . . . into bankruptcy, thereby ensuring that it would likely *never* have to  
26 pay for the services it authorized.”

27 **43.** The logic in *Bristol* also applies in assignments under California law,  
28 not just from patient to provider, but also to an assignee such as ABC. On January

1 20, 2022, the Ninth Circuit reversed and remanded the District Court’s dismissal of  
2 ABC’s ERISA claims for relief, holding that after the District Court issued its  
3 ruling, the Ninth Circuit’s opinion in *Bristol* clarified the ability of an assignee to  
4 bring an ERISA cause of action. [ECF No. 541.]

5 **44.** A general assignment for the benefit of creditors is a conveyance,  
6 without consideration, by a debtor of substantially all of the debtor’s property to an  
7 assignee in trust for the purpose of applying the property or its proceeds to the  
8 payment of the debtor’s debts and returning any surplus to the debtor. It is a  
9 voluntary transfer by a debtor of the debtor’s property to an assignee in trust for the  
10 purpose of applying the property thereof to the payment of the debtor’s debts. An  
11 assignment for the benefit of creditors is an alternative to a Chapter 7 bankruptcy  
12 liquidation, whereby the debtor assigns substantially all of its assets to the assignee  
13 instead of a bankruptcy trustee for the benefit of the debtor’s creditors.

14 **45.** On or about September 21, 2018, Morningside executed a written  
15 Assignment (the “**Morningside Assignment**”) pursuant to California Code of Civil  
16 Procedure §§ 493.010 through 493.060 and §§ 1800 through 18902. Pursuant to  
17 the Morningside Assignment, Morningside conveyed to ABC all of Morningside’s  
18 property and every right, claim and interest of Morningside, including the right to  
19 prosecute this action for the benefit of Morningside’s creditors. ABC brings this  
20 action in its capacity as the assignee for the benefit of creditors of Morningside  
21 pursuant to the Morningside Assignment. A true and correct copy of the  
22 Morningside Assignment is attached hereto and incorporated herein by this  
23 reference as Exhibit A.

24 **46.** At all relevant times herein, unless otherwise indicated, the  
25 Consolidated Defendants set forth in paragraphs 3, 4, and 5 were the agents and/or  
26 employees of each of the remaining Consolidated Defendants in those paragraphs  
27 and were at all times acting within the purpose and scope of said agency and  
28 employment, and each of these Defendants has ratified and approved the acts of the

1 agent. At all relevant times herein, each of these Consolidated Defendants set forth  
2 in paragraphs 3, 4, and 5 had actual or ostensible authority to act on each other's  
3 behalf in certifying or authorizing the provision of services, processing and  
4 administering the claims and appeals, pricing the claims, approving or denying the  
5 claims, directing each other as to whether and/or how to pay claims, issuing  
6 remittance advices and EOB statements, and making payments to Plaintiff and/or  
7 the Patients.

8 **47.** At all relevant times herein, unless otherwise indicated, the Defendants  
9 set forth in paragraphs 11, 12 and 13 were the agents and/or employees of each of  
10 the remaining Defendants in those paragraphs and were at all times acting within  
11 the purpose and scope of said agency and employment, and each of these  
12 Defendants has ratified and approved the acts of the agent. At all relevant times  
13 herein, each of the Defendants set forth in paragraphs 11, 12 and 13 had actual or  
14 ostensible authority to act on each other's behalf in certifying or authorizing the  
15 provision of services, processing and administering the claims and appeals, pricing  
16 the claims, approving or denying the claims, directing each other as to whether  
17 and/or how to pay claims, issuing remittance advices and EOB statements, and  
18 making payments to Plaintiff and/or the Patients.

19 **48.** At all relevant times herein, unless otherwise indicated, the Defendants  
20 set forth in paragraphs 14, 15, 16, 17, 18, were the agents and/or employees of each  
21 of the remaining Defendants in those paragraphs and were at all times acting within  
22 the purpose and scope of said agency and employment, and each of these  
23 Defendants has ratified and approved the acts of the agent. At all relevant times  
24 herein, each of the Defendants set forth in paragraphs 14, 15, 16, 17, 18 had actual  
25 or ostensible authority to act on each other's behalf in certifying or authorizing the  
26 provision of services, processing and administering the claims and appeals, pricing  
27 the claims, approving or denying the claims, directing each other as to whether  
28

1 and/or how to pay claims, issuing remittance advices and EOB statements, and  
2 making payments to Plaintiff and/or the Patients.

3 **49.** At all relevant times herein, unless otherwise indicated, the Defendants  
4 set forth in paragraphs 15, 16, 17, and 18 were the agents and/or employees of each  
5 of the remaining Defendants in those paragraphs and were at all times acting within  
6 the purpose and scope of said agency and employment, and each of these  
7 Defendants has ratified and approved the acts of the agent. At all relevant times  
8 herein, each of the Defendants set forth in paragraphs 22, 23, 24 had actual or  
9 ostensible authority to act on each other's behalf in certifying or authorizing the  
10 provision of services, processing and administering the claims and appeals, pricing  
11 the claims, approving or denying the claims, directing each other as to whether  
12 and/or how to pay claims, issuing remittance advices and EOB statements, and  
13 making payments to Plaintiff and/or the Patients.

14 **50.** At all relevant times herein, unless otherwise indicated, the Defendants  
15 set forth in paragraphs 21, 22, and 23 were the agents and/or employees of each of  
16 the remaining Defendants in those paragraphs and were at all times acting within  
17 the purpose and scope of said agency and employment, and each of these  
18 Defendants has ratified and approved the acts of the agent. At all relevant times  
19 herein, each of the Defendants set forth in paragraphs 21, 22, and 23 had actual or  
20 ostensible authority to act on each other's behalf in certifying or authorizing the  
21 provision of services, processing and administering the claims and appeals, pricing  
22 the claims, approving or denying the claims, directing each other as to whether  
23 and/or how to pay claims, issuing remittance advices and EOB statements, and  
24 making payments to Plaintiff and/or the Patients.

25 **51.** At all relevant times herein, unless otherwise indicated, the Defendants  
26 set forth in paragraphs 24, 25, and 26 were the agents and/or employees of each of  
27 the remaining Defendants in those paragraphs and were at all times acting within  
28 the purpose and scope of said agency and employment, and each of these



1 Defendants has ratified and approved the acts of the agent. At all relevant times  
2 herein, each of the Defendants set forth in paragraphs 24, 25, and 26 had actual or  
3 ostensible authority to act on each other's behalf in certifying or authorizing the  
4 provision of services, processing and administering the claims and appeals, pricing  
5 the claims, approving or denying the claims, directing each other as to whether  
6 and/or how to pay claims, issuing remittance advices and EOB statements, and  
7 making payments to Plaintiff and/or the Patients.

8 **52.** At all relevant times herein, unless otherwise indicated, the Defendants  
9 set forth in paragraphs 34 and 35 were the agents and/or employees of each of the  
10 remaining Defendants in those paragraphs and were at all times acting within the  
11 purpose and scope of said agency and employment, and each of these Defendants  
12 has ratified and approved the acts of the agent. At all relevant times herein, each of  
13 the Defendants set forth in paragraphs 24, 25, and 26 had actual or ostensible  
14 authority to act on each other's behalf in certifying or authorizing the provision of  
15 services, processing and administering the claims and appeals, pricing the claims,  
16 approving or denying the claims, directing each other as to whether and/or how to  
17 pay claims, issuing remittance advices and EOB statements, and making payments  
18 to Plaintiff and/or the Patients.

19 **53.** At all relevant times herein, unless otherwise indicated, the Defendants  
20 set forth in paragraphs 39, 40, and 41 were the agents and/or employees of each of  
21 the remaining Defendants in those paragraphs and were at all times acting within  
22 the purpose and scope of said agency and employment, and each of these  
23 Defendants has ratified and approved the acts of the agent. At all relevant times  
24 herein, each of the Defendants set forth in paragraphs 39, 40, and 41 had actual or  
25 ostensible authority to act on each other's behalf in certifying or authorizing the  
26 provision of services, processing and administering the claims and appeals, pricing  
27 the claims, approving or denying the claims, directing each other as to whether  
28



1 and/or how to pay claims, issuing remittance advices and EOB statements, and  
2 making payments to Plaintiff and/or the Patients.

### 3 **JURISDICTION AND VENUE**

4 **54.** Plaintiff brings this action for monetary relief pursuant to Section  
5 502(a)(1)(B) of ERISA, 29 U.S.C. §§ 1132(a)(1)(B). This Court has subject matter  
6 jurisdiction over Plaintiff's claims because the action seeks to enforce rights under  
7 ERISA pursuant to §§ 502(e) and (f), 29 U.S.C. §§ 1132(e) and (f), and 28 U.S.C. §  
8 1331.

9 **55.** This Court is the proper venue for this action pursuant to 8 U.S.C. §  
10 1392(b) because a substantial part of the events or omissions giving rise to the  
11 claims alleged herein occurred in this Judicial District, because one or more of the  
12 Defendants conducts a substantial amount of business in this Judicial District, and  
13 pursuant to 29 U.S.C. § 1132(e)(2) because it is the Judicial District in which the  
14 break occurred.

### 15 **INTRODUCTION**

16 **56.** The 2010 Patient Protection and Affordable Care Act (the "ACA" or  
17 "Affordable Care Act") required each health insurance issuer to accept every  
18 employer and individual in the state that applies for coverage, permitting annual  
19 and special open enrollment periods for those with qualifying lifetime events. 42  
20 U.S.C. § 300gg-1. The ACA further prohibited any group health plan or insurer  
21 offering group or individual coverage from imposing any preexisting condition  
22 exclusion or discriminating against those who have been sick in the past. 42 U.S.C.  
23 § 300gg-3. The ACA also prohibits any group health plan or insurer offering group  
24 or individual coverage from setting eligibility rules based on health status, medical  
25 condition, claims experience, receipt of health care, medical history, genetic  
26 information, and evidence of insurability, including acts of domestic violence or  
27 disability. 42 U.S.C. § 300gg-4. These requirements under the ACA also apply to  
28 ERISA plans. 29 U.S.C. § 1182.

1       **57.**       In 2014, the ACA required health insurance plans, including those sold  
2 by Consolidated Defendants, to provide ten categories of “essential health  
3 benefits,” including mental health substance abuse treatment. 42 U.S.C. § 18022.  
4 Plaintiff is informed and believes, and based thereon alleges, that each of the  
5 Consolidated Defendants marketed new plans that reimbursed out-of-network  
6 providers of SUD treatment like Morningside.

7                               **THE MORNINGSIDE SERVICES**

8       **58.**       At all relevant times herein, Morningside provided a finite number of  
9 services to its patients, all of which are identified by either the Healthcare Common  
10 Procedure Coding System (“**HCPCS**”) Codes or the Current Procedural  
11 Terminology (“**CPT**”) Codes (collectively the “**Morningside Services**”), including  
12 but not limited to the following:

- 13               a.       H0010: alcohol and/or drug services, sub-acute detoxification  
14                       (residential addiction program inpatient);
- 15               b.       H0018: alcohol and drug abuse treatment services, short-term  
16                       residential treatment (non-hospital);
- 17               c.       H0035: partial hospitalization treatment;
- 18               d.       H0015: intensive outpatient program;
- 19               e.       90792: psychiatric diagnostic evaluation;
- 20               f.       H0048, 80320, 80305, G0434, and G0477: drug testing  
21                       procedures;
- 22               g.       90876, 90837 and 90853: individual and group therapy sessions.

23       **59.**       Each of the HCPCS and CPT codes falls into the category of mental  
24 health and substance use disorder services. Mental health and substance use  
25 disorder services, including behavioral health treatment, are “essential health  
26 benefit[s]” under the Affordable Care Act. 42 U.S.C. § 18022(b)(1)(E). To be a  
27 “qualified health plan” under the Affordable Care Act, a health plan, in part, must  
28

1 provide the essential health benefits set forth in Section 18022. 42 U.S.C. §  
2 18021(a)(1)(B).

3 **60.** At all relevant times herein, Morningside was a non-contracting (as to  
4 Consolidated Defendants) mental and SUD treatment and rehabilitation facility  
5 operating in Orange County, California, also referred to as a “non-contracted” or  
6 “out-of-network” provider. At all relevant times herein, Morningside offered a  
7 therapeutically planned rehabilitation intervention environment for the treatment of  
8 individuals with behavioral concerns and SUD.

9 **61.** Plaintiff is informed and believes, and based thereon alleges, that  
10 Consolidated Defendants generally enter into private agreements with health care  
11 facilities thereby extending to them “in network” provider status. Out-of-network  
12 claims are distinguished by the fact that when members/patients obtain health care  
13 services from an out-of-network provider, like Morningside, members/patients are  
14 responsible for charges that the plan might not cover, or that exceed Consolidated  
15 Defendants’ reimbursement obligation to members/patients under the Plans.

16 **62.** Plaintiff is informed and believes, and based thereon alleges, that this  
17 practice is known to Consolidated Defendants and others in the industry as  
18 “steerage”, which is a method by which facilities that maintain in-network status  
19 may refer patients to each other pursuant to in-network agreements. Plaintiff is  
20 further informed and believes, and based thereon alleges, that Consolidated  
21 Defendants conclude that referrals to and amongst facilities within the in-network  
22 community are permitted without fear of reprisal by state regulatory commissions  
23 that prohibit patient referrals for a fee, and the in-network status also protects  
24 members/patients from incurring excessive facility charges that are often imposed  
25 when a patient uses an out-of-network facility.

26 **63.** Morningside provided and rendered services, SUD and/or mental health  
27 treatment to members, subscribers and insured of Consolidated Defendants, each of  
28 whom was a patient of Morningside and hereinafter referred to collectively as the

1    **“Patients”** or the **“Morningside Patients”**. As a result, Plaintiff became entitled to  
2    reimbursement, remuneration and/or payment from Consolidated Defendants for  
3    those services and supplies Morningside rendered to the Patients.

4       **64.**     Plaintiff is informed and believes, and based thereon alleges, that some  
5    or all of the Patients had express coverage for mental health and SUD treatment  
6    services as a delineated benefit of an ERISA plan, summary plan descriptions, and  
7    policies which were underwritten and/or administered by Consolidated Defendants  
8    (individually an **“ERISA Plan”** or collectively the **“ERISA Plans”**).

9       **65.**     Plaintiff is informed and believes, and based thereon alleges, that some  
10   or all of the Patients were plan participants and/or beneficiaries of an Employee  
11   Welfare Plan under ERISA, as those terms are defined by 20 U.S.C. § 1002.

12   Plaintiff is further informed and believes, and based thereon alleges, that some or  
13   all of the Patients were entitled to be reimbursed for the cost of mental health and  
14   SUD treatment as the benefit of the subject Consolidated Defendants’ plans,  
15   policies and insurance agreements governing the relationship between each Patient  
16   and a Consolidated Defendant (collectively the **“ERISA PLANS”**. Each of the  
17   Plans provided coverage for both in and out-of-network mental health providers,  
18   and for admission to treatment centers for SUD treatment by SUD treatment  
19   providers and related services received on an outpatient basis, inpatient basis,  
20   partial inpatient basis and/or intensive outpatient basis, including but not limited to  
21   coverage for facility charges, psychotherapy, psychiatrists, psychologists, charges  
22   for supplies and equipment, physician services, blood testing and other incidental  
23   services.

24       **66.**     Plaintiff is informed and believes, and based thereon alleges, that the  
25   Patients had preferred provider organization (**“PPO”**) plan benefits or point of  
26   service (**“POS”**) plan benefits that allowed them to seek medically necessary  
27   benefits, whether in-network or not and were entitled to reimbursement for their  
28   claims because Plaintiff was an out-of-network provider for Consolidated

1 Defendants. The Patients' claims should not have been denied or underpaid as the  
2 Plans provide coverage for the very services performed by Morningside, including  
3 but not limited to coverage for mental and SUD treatment.

4 **67.** Plaintiff is informed and believes, and based thereon alleges, that each  
5 of the Patients whose claims are at issue in this lawsuit required treatment for SUD  
6 and/or were suffering from serious medical and mental health concerns, sometimes  
7 related to their addictions and sometimes unrelated. Each of the Patients chose  
8 PPO insurance rather than health maintenance organization ("HMO") insurance  
9 through their employers so that they could receive plan benefits from the physicians  
10 and other medical providers of their choice, regardless of whether the health care  
11 practitioners were in-network or out-of-network with Consolidated Defendants.  
12 Consolidated Defendants, who administer and/or underwrite the PPO insurance for  
13 the Patient's employers, advertise, publicize and represent on their websites, in  
14 their literature and in commercials that the benefit of their PPO policies include the  
15 freedom to choose any doctor for any and all health care needs.

16 **68.** Morningside requested that Consolidated Defendants authorized the  
17 Patients to undergo treatment at Morningside for SUD treatment and for  
18 Consolidated Defendants to authorize Morningside to provide the same treatment  
19 and care to the Patients. Plaintiff is informed and believes, and based thereon  
20 alleges, that Consolidated Defendants authorized the Patients to undergo mental  
21 health and SUD treatment at Morningside and verified that each of the Patients had  
22 coverage which included coverage for the treatment Morningside provided.

23 **69.** Plaintiff is informed and believes, and based thereon alleges, that no  
24 provisions in any of the ERISA Plans, whether in the Summary Plan Descriptions  
25 ("SPDs") and/or Evidence of Coverage ("EOC") documents justified the failure of  
26 Consolidated Defendants to pay the fees for services charged by mental health care  
27 providers or by SUD treatment facilities, like Morningside, whether by  
28 underpayment or to pay nothing. These actions by Consolidated Defendants were

1 arbitrary, capricious and improper. Plaintiff is further informed and believes, and  
2 based thereon alleges, that during the insurance verification process for the  
3 Patients, Consolidated Defendants represented to Morningside that they would pay  
4 Morningside's fees. Morningside sought information during this process about  
5 potential limitations on the reimbursement of Morningside's fees each time prior to  
6 providing services, and specifically inquired as to how Consolidated Defendants'  
7 fee provisions would apply to the Patients.

8 **70.** In the alternative, Plaintiff is informed and believes, and based thereon  
9 alleges, that Consolidated Defendants may have withheld information in response  
10 to such requests, and therefore misled Morningside into believing that services  
11 rendered by Morningside would be paid.

12 **71.** Plaintiff is informed and believes, and based thereon alleges, that no  
13 provisions in the ERISA Plans justified the failure to issue a final decision or denial  
14 on any of the Patient claims, and no provision in the subject Plans justified the  
15 failure and refusal of Consolidated Defendants to issue an EOB statement,  
16 delineating and explaining the justification or rationale for refusing to pay, cover  
17 and reimburse the Patient claims or to adjust those claims. These failures and  
18 refusals by Consolidated Defendants were therefore arbitrary, capricious and a  
19 breach of Consolidated Defendants' fiduciary duties to ERISA Plan participants.  
20 These failures and refusals were also violative of regulations promulgated under  
21 ERISA by the Department of Labor, which require that claims be adjudicated by  
22 the claims administrator (*e.g.*, Consolidated Defendants) within 45 days after  
23 receipt of the claim and were also violative of the Plans and SPDs issued and  
24 adopted by Consolidated Defendants.

25 **72.** Plaintiff is informed and believes, and based thereon alleges, that for  
26 each ERISA Plan involved in this lawsuit, the terms of the ERISA Plan: (a)  
27 provided coverage for each of the services, supplies and treatments rendered by  
28 Morningside to each Patient for whom reimbursement, payment and coverage is

1 sought; and (2) dictated that these covered services be paid according to a specific  
2 reimbursement rate (such as the reasonable and customary fees for services charged  
3 by Morningside or according to other formulae or allowable rates expressly and  
4 specifically provided in the ERISA Plans) (the “**UCR Rate**”). according these  
5 covered services be paid according to a specific reimbursement rate (such as the  
6 reasonable and customary fees for services charged by Morningside or according to  
7 other formulae or allowable rates expressly and specifically provided in the ERISA  
8 Plans.

9       **73.** Each of the Patients have assigned all of their legal and equitable rights  
10 to payment and to assert ERISA remedies under the ERISA Plans to Morningside  
11 in writing, including but not limited to their rights to recover the benefits owed to  
12 them by Consolidated Defendants to Plaintiff, by and through an irrevocable  
13 assignment of all of their rights, title and interest in and to the claims against  
14 Consolidated Defendants. These assignments conferred upon Morningside the  
15 right to stand in the shoes of the Patients and to assert all of the rights held by the  
16 Patients as to Consolidated Defendants and/or as to the ERISA Plans administered  
17 by Consolidated Defendants, including but not limited to all rights, powers and  
18 equitable remedies of the Patients, the right of Plaintiff to substitute in as a party or  
19 plaintiff in any past, present or future litigation regarding the Patient’s claims  
20 against Consolidated Defendants, the right to the proceeds of all legal fees and  
21 costs, if specifically awarded, and any interest if specifically awarded, and the right  
22 to make and effect collections, including the commencement of legal proceedings  
23 on behalf of the Patients. A true and correct copy of sample assignments signed by  
24 the Patients is attached hereto and incorporated herein by this reference as Exhibit  
25 B as if set forth in full.

26       **74.** In compliance with the terms of each ERISA Plan, Plaintiff and/or the  
27 Patients have exhausted any and all claims review, grievance, administrative  
28 appeals, and appeals requirements by submitting letters, appeals, grievances,



1 requests for reconsideration and request for payment from Consolidated  
2 Defendants.

3       **75.**       Alternatively, all review, appeal, administrative grievances or  
4 complaint procedures are excused as a matter of law, are violative of Plaintiff's due  
5 process rights, are or would be futile, or are otherwise unlawful, null, void and  
6 unenforceable. Consolidated Defendants' pattern of behavior and refusal to  
7 reimburse Plaintiff rendered all potential administrative remedies futile. As a result  
8 of Consolidated Defendants' actions and/or omissions, Consolidated Defendants  
9 are estopped from asserting that Morningside or Plaintiff has failed to exhaust its  
10 administrative remedies under ERISA. Alternatively, by Consolidated Defendants'  
11 failure and refusal to establish, maintain and follow a reasonable claim procedure  
12 process, Plaintiff and/or the Morningside Patients have exhausted the  
13 administrative remedies available under the ERISA Plans and are entitled to pursue  
14 this action, inasmuch as Consolidated Defendants have failed to provide a  
15 reasonable claims procedure that would yield a decision on the merits of the claim,  
16 in violation of 29 C.F.R. § 2560.503-1(l).

17                               **PROCEDRAL HISTORY**

18       **76.**       On May 4, 2020, this Court dismissed Plaintiff's ERISA Claims for  
19 relief against the Consolidated Defendants with prejudice [ECF No. 383, pp. 4-5].

20       **77.**       On August 5, 2020, Plaintiff filed its Notice of Appeal to the Ninth  
21 Circuit Court of Appeals. [ECF No. 451.]

22       **78.**       On January 20, 2022, the Ninth Circuit Court of Appeals issued a  
23 Memorandum affirming in part and reversing in part this Court's previous  
24 dismissal. [ECF No. 541.]

25       **79.**       On February 11, 2022, the Ninth Circuit Court of Appeals issued a  
26 formal mandate pursuant to Rule 41(a) of the Federal Rules of Appellate  
27 Procedure.  
28



**ERISA PLAN LANGUAGE COMMON TO ALL**  
**MORNINGSIDE PATIENTS**

1  
2  
3       **80.**       Plaintiff is informed and believes, and based thereon alleges, that each  
4 of the ERISA Plans at issue for the Consolidated Defendants contains and “out-of-  
5 pocket” maximum amount applicable to each patient.

6       **81.**       Plaintiff is informed and believes, and based thereon alleges, that  
7 Defendants generally enter into private agreements with health care facilities  
8 thereby extending to them “in network” provider status. Out-of-network claims are  
9 distinguished by the fact that when members/patients obtain health care services  
10 from an out-of-network provider, like Morningside, members/patients are  
11 responsible for charges that the plan might not cover, or that exceed Defendants’  
12 reimbursement obligation to members/patients under the Plans.

13       **82.**       Each of the Patients have assigned to Morningside all of their legal and  
14 equitable rights to payment under California law with respect to the Plans in  
15 writing, including but not limited to their rights to recover the benefits owed to  
16 them by Defendants to Morningside, by and through an irrevocable assignment of  
17 all of their rights, title and interest in and to the claims against Defendants. These  
18 assignments conferred up on Morningside and/or Plaintiff the right to stand in the  
19 shoes of the Patients and to assert all of the rights held by the Patients as to  
20 Defendants and/or as to the Plans administered by Defendants, including but not  
21 limited to all rights, powers and equitable remedies of the Patients, the right of  
22 Plaintiff to substitute in as a party or plaintiff in any past, present or future litigation  
23 regarding the Patient’s claims against Defendants, the right to the proceeds of all  
24 legal fees and costs, if specifically awarded, and any interest if specifically  
25 awarded, and the right to make and effect collections, including the commencement  
26 of legal proceedings on behalf of the Patients. *See Exhibit B.*

27  
28

**PLAINTIFF'S CLAIMS AGAINST CONSOLIDATED DEFENDANTS**

**83.** Plaintiff alleges below claims for relief against each of the Consolidated Defendants that includes:

- a. United Healthcare Services, Inc. (“UHS”), United Behavioral Health (“UBH”) and Optum Services, Inc. (“Optum”, together with UHS and UBH collectively the “**United Healthcare Defednants**”), original filing 8:19-cv-00531-DOC-DFM;
- b. USAbile Mutual Insurance Company, dba Arkansas Blue Cross and Blue Shield and as Blue Advantage Administrators of Arkansas (collectively **BCBS Arkansas**”), original filing 8:19-cv-00803-DOC-DFM;
- c. Blue Cross and Blue Shield of Kansas City (“**BCBS KC**”), original filing 8:19-cv-00803-DOC-DFM;
- d. Blue Cross and Blue Shield of Kansas, Inc. (“**BCBS KI**”), original filing 8:19-cv-00803-DOC-DFM;
- e. Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company (“**BCBS Miss**”), original filing 8:19-cv-00803-DOC-DFM;
- f. Health Care Service Corporation, a Mutual Legal Reserve Company, dba Blue Cross and Blue Shield of Oklahoma (“**BCBS Ok**”), original filing 8:19-cv-00776-DOC-DFM;
- g. Blue Cross and Blue Shield of Alabama (“**BCBS Ala**”), original filing 8:19-cv-00789-DOC-DFM,
- h. Anthem Blue Cross Life and Health Insurance Company, Anthem, Inc., Anthem, Inc. dba Anthem Health, Inc., The Anthem Companies of California, Inc. and The Anthem Companies, Inc. (collectively, the “**Anthem Defendants**”), original filing 8:19-cv-00677-DOC-DFM;

- i. Humana Insurance Company, Humana Employers Health Plan of Georgia, Inc., Humana Behavioral Health, Inc., Humana Health Plan of California, Inc., Humana Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Texas, Inc., Humana Health Plan, Inc., and Humana Medical Plan (erroneously sued as Humana Insurance Company and Humana Medical Plan) (collectively the “**Humana Defendants**”), original filing 8:19-cv-00317-DOC-DFM;
- j. Aetna Health and Life Insurance Company (“**Aetna**”), original filing 8:19-cv-00777-DOC-DFM;
- k. Bluecross Blueshield of Tennessee, Inc. (“**BCBS Tenn**”), original filing 8:19-cv-00804-DOC-DFM;
- l. ComPsych Corporation (“**ComPsych**”), original filing 8:19-cv-02123-DOC-DFM;
- m. Cigna HealthCare of California, Inc., Cigna Behavioral Health of California, Inc., and Cigna Health and Life Insurance Company (collectively the “**Cigna Defendants**”), original filing 8:19-cv-02125-DOC-DFM;
- n. HMC Healthworks, Inc., now known as HMC Healthworks, LLC (“**HMC**”), original filing 8:19-cv-02136-DOC-DFM;
- o. United Medical Resources, Inc. (“**UMR**”), original filing 8:19-cv-02138-DOC-DFM;
- p. Sierra Health and Life Insurance Company, Inc. (“**Sierra**”), original filing 8:19-cv-02168-DOC-DFM;
- q. Medical Mutual of Ohio and Medical Mutual Services, LLC (collectively the “**Medical Mutual Defendants**”), original filing 8:19-cv-02122-DOC-DFM;

- r. Group Health Plan, Inc., dba Healthpartners (“**GHP**”), original filing 8:19-cv-02242-DOC-DFM;
- s. Meritain Health, Inc. (“**Meritain**”), original filing 8:19-cv-02182-DOC-DFM);
- t. Beacon Health Options, Inc., Beacon Health Strategies, LLC, Valueoptions Federal Services, Inc. and Valueoptions of California, Inc. (collectively the “**Beacon Defendants**”), original filing 8:19-cv-02204-DOC-DFM;
- u. Coventry Health Care, Inc. (“**Coventry**”), original filing 8:19-cv-02131-DOC-DFM (previously 8:19-cv-09432-DOC-DFM);
- v. MHNet Specialty Services, LLC (“**MHNet**”), original filing 8:19-cv-02219-DOC-DFM;
- w. Providence Health Plan (“**Providence**”), original filing 8:19-cv-02172-DOC-DFM;
- x. First Health Group Corporation (“**First Health**”), original filing 8:19-cv-02171-DOC-DFM; and
- y. GHI Inc. (“**GHI**”), original filing 8:19-cv-02129-DOC-DFM.

84. The Patients have not been identified by name in this Complaint to protect their right of privacy. Plaintiff provided detailed information to Consolidated Defendants regarding treatment and services for Patients in each of the lawsuits at issue in this action, and as further set forth below. Plaintiff is informed and believes, and based thereon alleges, that for each Consolidated Defendant, counsel for Plaintiff has produced detailed information for each of the Patients.

85. Each of the Patients received the Morningside Services. Payments are due and owing by Consolidated Defendants to Plaintiff for the care, treatment and procedures provided to the Patients, all of whom were insured, members, policy holders, certificate holders or otherwise covered for charges by Morningside

1 through policies or certificates of insurance issued, underwritten and/or  
2 administered by Consolidated Defendants.

3 **86.** Plaintiff is informed and believes, and based thereon alleges, that each  
4 of the Patients for whom claims are at issue was an insured of Consolidated  
5 Defendants either as a subscriber to coverage or a dependent of a subscriber to  
6 coverage under a policy or certificate of insurance issued, administered and/or  
7 underwritten by Consolidated Defendants. Plaintiff is further informed and  
8 believes, and based therein alleges, that each of the Patients for whom claims are at  
9 issue was covered by a valid insurance agreement with Defendants for the specific  
10 purpose of ensuring that the Patients would have access to medically necessary  
11 treatments, care, procedures and related care by out-of-network providers such as  
12 Morningside.

13 **87.** In the alternative, Plaintiff is informed and believes, and based thereon  
14 alleges, that some of the Patients for whom claims are at issue were covered by  
15 self-funded plans which were administered by Defendants. The identify of those  
16 Plans which are self-funded is known to Defendants, but only known in part to  
17 Plaintiff. Those self-funded Plans provided coverage to the Patients either as a  
18 subscriber to coverage or as a dependent of a subscriber to coverage under the  
19 certificate of coverage administered by Consolidated Defendants.

20 **88.** Plaintiff is informed and believes, and based thereon alleges, that each  
21 of the Patients for whom claims are at issue was covered by a valid benefit plan,  
22 providing coverage for medical and mental health expenses, for the specific  
23 purpose of ensuring that the Patients would have access to medically necessary  
24 treatments, care and procedures by out-of-network providers like Morningside and  
25 ensuring Consolidated Defendants would pay for the health care expenses incurred  
26 by the Patients for the services rendered by Morningside.

27 **89.** At all relevant times, each of the Patients received medical and/or  
28 paramedical services, procedures, mental health care, SUD treatment or other

1 health care services from Morningside. Upon rendition of services to each of the  
2 Patients, each of the Patients became legally indebted, responsible and liable to  
3 Plaintiff for the full cost of and for payment of those services. Prior to the rendition  
4 of care by Morningside, Morningside sought and obtained a guarantee from the  
5 Patients that they would be legally responsible, liable and indebted for the full cost  
6 of and for payment of those services to be rendered by Morningside.

7 **90.** Each of the Patients requested Morningside to render and provide  
8 medical treatment and professional services, knowing that Morningside was an out-  
9 of-network provider. Each of the Patients sought out, requested and requisitioned  
10 treatment and professional services from Morningside and selected and chose  
11 Morningside to provide him or her with said services based upon Morningside's  
12 reputation in the community, experience and availability to render immediate care.  
13 Each of the Patients signed written admission agreements in which the Patients  
14 agreed to be obligated, legally responsible and liable for the full amount of the  
15 charges incurred for services rendered at Morningside.

16 **91.** Each of the Patients presented his or her insurance card to Morningside,  
17 which card identified the Patient as an insured, subscriber and/or member of  
18 Defendants. These identification cards, which were issued by Defendants, did not  
19 identify whether the coverage was underwritten by Defendants as an insurer or  
20 whether Defendants was acting as a third-party administrator of a self-funded plan.

21 **92.** Plaintiff is informed and believes, and based thereon alleges, that each  
22 and every one of the Patients had express coverage for mental health and SUD  
23 treatment benefits under the applicable Plan or policy covering that Patient which  
24 was issued or administered by Defendants. As such, each Plan was required to  
25 offer coverage for mental health and SUD treatment in parity with the medical and  
26 surgical benefits afforded by the same plan, as required by 26 U.S.C. § 9812(3)(A),  
27 which mandates that:  
28

1 In the case of a group health plan that provides both medical and surgical  
2 benefits and mental health or substance use disorder benefits, such plan shall  
3 ensure that –

4 i. the financial requirements applicable to such mental health or  
5 substance use disorder benefits are no more restrictive than the  
6 predominant financial requirements applied to substantially all  
7 medical and surgical benefits covered by the plan, and there are  
8 no separate cost sharing requirements that are applicable only  
9 with respect to mental health or substance use disorder benefits;  
10 and

11 ii. the treatment limitations applicable to such mental health or  
12 substance use disorder benefits are no more restrictive than the  
13 predominant treatment limitations applied to substantially all  
14 medical and surgical benefits covered by the plan and there are  
15 no separate treatment limitations that are applicable only with  
16 respect to mental health or substance use disorder benefits.

17 **93.** Additionally, 26 U.S.C. § 9812(5) mandates that out-of-network  
18 providers such as Morningside be treated in parity with medical providers and with  
19 in-network providers of mental health and SUD treatment, stating:

20 In the case of a plan that provides both medical and  
21 surgical benefits and mental health or substance use disorder  
22 benefits, if the plan provides coverage for medical or surgical  
23 benefits provided by out-of-network providers, the plan shall  
24 provide coverage for mental health or substance use disorder  
25 benefits provided by out-of-network providers in a manner that  
26 is consistent with the requirements of this section.

27 **94.** Federal law also requires that insurers and Plans articulate the reason  
28 and rationale for any denial of benefits, stating:



1           The criteria for medical necessity determinations made  
2           under the plan with respect to mental health or substance use  
3           disorder benefits shall be made available by the plan  
4           administrator in accordance with regulations to any current or  
5           potential participant, beneficiary, or contracting provider upon  
6           request. The reason for any denial under the plan of  
7           reimbursement or payment for services with respect to mental  
8           health or substance use disorder benefits in the case of any  
9           participant or beneficiary shall, on request or as otherwise  
10          required, be made available by the plan administrator to the  
11          participant or beneficiary in accordance with regulations

12          **95.**   The failure and refusal of Consolidated Defendants to articulate the  
13          reasons, rationales and/or criteria it used in denying benefits for coverage for the  
14          Patients' claims constitutes a breach of 26 U.S.C. § 9812(4) and the applicable  
15          regulations promulgated thereunder.

16          **96.**   The failure and refusal of Defendants to pay Plaintiff for the SUD  
17          treatments rendered by Morningside to the Patients violated 26 U.S.C. § 9812(3)  
18          per se. Plaintiff is informed and believes, and based thereon alleges, that  
19          Defendants has discriminated against it and other mental health and SUD treatment  
20          providers by applying financial requirements and treatment limitations different  
21          than those applied to medical health providers.

22          **97.**   Plaintiff is informed and believes, and based thereon alleges, that  
23          Consolidated Defendants has investigated, adjusted, processed and examined  
24          Plaintiff's claims, in a manner different than the manner in which it investigates,  
25          adjusts, processes and examines the claims of medical providers, by subjecting  
26          Plaintiff's claims to delays, by requesting additional information which is  
27          irrelevant to the claim process, by offsetting payments it acknowledged were owed  
28          on claims for the Patients by amounts owed on account of other patients who were



1 not related to the Patients but who were insured by Defendants and who had  
2 received SUD treatments at Plaintiff at different times when treatment had been  
3 rendered to the Patients. As a result, Defendants has breached the statutory  
4 mandates of 26 U.S.C. § 9812, *et. seq.*, and Defendants owe payment benefits to  
5 Plaintiff in an amount to be proven at trial, but no less than \$75,000,000.00.

6 **98.** At all relevant times herein, Morningside and Plaintiff were  
7 authorized by law to act on behalf of the Patient with respect to the filing of claims  
8 with Consolidated Defendants, demanding production of documents from  
9 Consolidated Defendants, and filing further requests as necessary.

10 **99.** Other than those documents provided by Consolidated Defendants,  
11 Plaintiff is not privy to, nor does it possess or have access to, any other EOC  
12 documents, Plan Documents, policies or Certificates of Insurance which may be  
13 issued to the Patients. As such, in many instances Plaintiff does not have  
14 knowledge of or access to the definition of an “allowable amount” or “allowable  
15 benefit” as that term is defined or used by Consolidated Defendants, at any time  
16 prior to the date that Consolidated Defendants processes, adjusts and pays each  
17 claim. These definitions were not imparted by Consolidated Defendants to  
18 Morningside during the insurance verification or authorization process.

19 **100.** At all relevant times herein, Consolidated Defendants have  
20 improperly payed, or failed/refused to pay anything to Morningside for the  
21 medically necessary and appropriate services rendered to Defendants’ insureds,  
22 subscribers and members for those treatments, services and/or supplies rendered by  
23 Morningside. For each of the Patient claims at issue in this action, Morningside  
24 provided medical services to members and insureds of Defendants.

25 **101.** Following the rendition of treatment by Morningside to the Patients,  
26 invoices, bill and claims were submitted to Defendants for adjustment and  
27 payment. Morningside also provided medical records to Defendants for the  
28 treatment Morningside provided to the Patients.

1           **102.** For each of the claims at issue, Consolidated Defendants failed and  
2 refused to adjust the claims and to issue EOB statements to Morningside in a  
3 timely manner, if so required by state law. These failures constituted an effective  
4 denial of benefits, although an actual denial of benefits was not communicated by  
5 Defendants. By virtue of its failure and refusal to issue EOB statements and to  
6 adjust the claims, Plaintiff was precluded and inhibited from appealing the  
7 effective denial of payment on the subject claims, to the extent such actions were  
8 required by Morningside, as applicable.

9           **103.** For each of the claims at issue in this case, Consolidated Defendants  
10 failed and refused to complete the claim examination process, delayed issuing  
11 EOB and EOP statements to Morningside, has requested unnecessary and  
12 irrelevant information and documentation from Morningside which has no bearing  
13 on or relevant to the claim examination process, has failed and refused to provide  
14 notification of the reasons for its failure and refusal to pay benefits and has failed  
15 to engage in a meaningful appeal process with Morningside. For each of the  
16 claims at issue in this case, Defendants has failed and refused to pay benefits in  
17 any amount whatsoever, leaving the entire charges unpaid and owed.

18           **104.** To the extent Defendants issued any EOB statements, Defendants did  
19 not explain how the claims were adjusted, disallowed or denied, and Defendants  
20 provided vague, ambiguous and uncertain explanations for the manner by which  
21 Defendants based its claim determination. To the extent Defendants issued any  
22 EOB statements, each was uninformative, false and misleading, thereby depriving  
23 Plaintiff and the Patients from an ability to intelligently engage in the appeal  
24 process or understand the basis and rationale for Defendants' denial of benefits.

25           **105.** In each of the EOB statements issued by Consolidated Defendants, if  
26 any, Consolidated Defendants failed to advise Plaintiff and/or the Patients of the  
27 right of the Patients and/or Plaintiff to appeal the adverse claim determination  
28 made by Defendants in any of the EOB statements concerning the right to appeal,

1 file a grievance, seek reconsideration or otherwise engage in an administrative  
2 review process, as required by Consolidated Defendants under California state law.

3 **FIRST CLAIM FOR RELIEF**

4 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

5 **Against the United Healthcare Defendants)**

6 **106.** Plaintiff realleges and incorporates by reference each and every  
7 paragraph of this Complaint as though set forth herein.

8 **107.** This Claim for Relief applies only to defendants United Healthcare  
9 Services, Inc, United Behavioral Health and Optum Services, Inc. (collectively the  
10 “**United Healthcare Defendants**”), originally named as defendants by Plaintiff in  
11 case number 8:19-cv-00531-DOC-DFM.

12 **108.** Plaintiff is informed and believes, and based thereon alleges, that  
13 Morningside provided treatment for patients insured for SUD and/or mental health  
14 treatment by the United Healthcare Defendants under an ERISA Plan issued,  
15 underwritten and/or administrated by the United Healthcare Defendants and/or the  
16 predecessor(s), assignor(s), agent(s), alter ego(s) or related entities of the United  
17 Healthcare Defendants.

18 **109.** Plaintiff is informed and believes, and based thereon alleges, that  
19 Defendants are discriminating against the Patients of Plaintiff who are suffering  
20 from a severe mental illness or SUDs by restricting benefits that are not imposed  
21 on other patients.

22 **110.** This claim is alleged by Plaintiff for relief in connection with claims  
23 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
24 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
25 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
26 Patients’ benefits under the ERISA Plans. As the assignee of benefits under the  
27 ERISA Plans, Plaintiff is a “beneficiary” entitled to collect benefits under the terms  
28 of the ERISA Plans, and is the “claimant” for purposes of ERISA.

1       **111.** Plaintiff is informed and believes, and based thereon alleges, that the  
2 United Healthcare Defendants are the insurer, sponsor, and/or financially  
3 responsible payer, serve as a designated plan administrator, and/or services as the  
4 named plan administrator's designee. Plaintiff is further informed and believes,  
5 and based thereon alleges, that with respect to each of the ERISA Plans at issue in  
6 this case that are self-insured plans, but which do not specifically designate a plan  
7 administrator, the United Healthcare Defendants effectively control the decision  
8 whether to honor or deny the a claim under the Plan, exercise authority over the  
9 resolution of benefits claims, and/or have responsibility to pay the claims. The  
10 United Healthcare Defendants also play the role as the *de facto* plan administrator  
11 for such ERISA Plans.

12       **112.** The United Healthcare Defendants previously argued in their motion  
13 to dismiss that Plaintiff had not sufficiently alleged a claim under ERISA because  
14 the operative complaint did not identify the particular services provided by  
15 Morningside to each patient or the plan terms that obligated these defendants to  
16 cover these services. [United Health Litigation, ECF No. 17]. This Court denied  
17 the motion to dismiss the ERISA claim for relief.<sup>3</sup> [ECF No. 31, p. 7].

18       **113.** At the June 17, 2019 Status Conference in the lawsuit against the  
19 United Health Litigation, the Hon. David O. Carter discussed plan documents with  
20 counsel for Plaintiff and Defendants:

21       THE COURT: In the minute order, I ordered plaintiff to amend the  
22 Complaint in the ruling on the motion to dismiss. And I'm concerned  
23 that there -- you may want discovery of documents for patients  
24 involved, obviously, in this lawsuit. So you only had one plan  
25 document that you submitted to me. How many other plan documents  
26 do we have?

---

27  
28       <sup>3</sup> A true and correct copy of this Order is attached as Exhibit C to this  
Complaint and incorporated herein by this reference.

1 MR. GARNER: Your Honor, the one plan document was submitted  
2 by defendants.

3 THE COURT: And that's all we have so far. And you were  
4 complaining. You were concerned about that. You said, Judge, we  
5 have one plan document. I'm gonna ask you again: How many  
6 documents do we have?

7 MR. GLASSMAN: My understanding's that they're bringing the case  
8 on behalf of approximately 150 patients.

9 THE COURT: Yeah.

10 MR. GLASSMAN: So we're talking 150 plan documents.

11 \*\*\*\*\*

12 THE COURT: Okay. So you need those plan documents?

13 MR. GARNER: That's correct.

14 THE COURT: And, of course, that's burdensome?

15 MR. GLASSMAN: It is a little burdensome, yes, Your Honor.

16 THE COURT: But we can get those?

17 MR. GLASSMAN: But we can get those.

18 THE COURT: . . . And, therefore, unfortunately I'm gonna need a  
19 special master to wade through this 'cause I'm not gonna tie up my  
20 magistrate judge with this. So we need a special master. And we need  
21 to find that person today . . .

22 [ECF No. 37, Transcript from June 17, 2019 Status Conference, United  
23 Health Litigation, 5:3 to 7:8, a true and correct copy of which is attached as  
24 Exhibit D and incorporated herein by this reference].

25 **114.** To ensure that the United Healthcare Defendants produced the ERISA  
26 (and other) plan documents, the District Court appointed Robert O'Brien as the  
27 Special Master in this case, charged in part with the task of facilitating production  
28 of these plan documents from the United Defendants to Plaintiff. "Among other

1 things, the Parties believe the Special Master may help facilitate the exchange of  
2 information, including the identification and production of benefit plan documents  
3 and administrative records related to the benefit claims at issue. . . .” [ECF No. 47,  
4 2:27 to 3:3, United Healthcare Litigation, a true and correct copy of which is  
5 attached as Exhibit E and incorporated herein by this reference].

6 **115.** With respect to the ERISA Plans provided by the United Healthcare  
7 Defendants, Plaintiff’s claims against the United Healthcare Defendants includes  
8 152 patients of Morningside. To date, there remains a balance due and owing by  
9 the United Healthcare Defendants to Plaintiff in the amount of \$6,153,607.90.

10 **116.** As this Court previously denied the motion to dismiss the ERISA  
11 claims for relief filed by Plaintiff against the United Healthcare Defendants,  
12 Plaintiff and the United Healthcare Defendants have already exchanged the  
13 relevant patient information, and in particular the information related to the ERISA  
14 Plan patients. The United Healthcare Defendants still must produce ERISA Plan  
15 documentation for 58 patients, notwithstanding the order from the previous Special  
16 Master.

17 **117.** Plaintiff is informed and believes, and based thereon alleges, that for  
18 each of these claims and for each of the involved Patients, Defendants have failed  
19 and refused to pay, process or adjust these claims in an appropriate fashion by,  
20 among other acts and omissions:

21 **a.** Delaying the processing, adjustment and/or payment of  
22 claims for periods of time greater than 45 days after submission of the  
23 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

24 **b.** Failing and refusing to provide any notice and/or  
25 explanation for the denial of benefits, payments or reimbursement of  
26 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);  
27  
28

1           **c.**     Failing and refusing to provide an adequate notice and/or  
2           explanation for the denial of benefits, payments or reimbursement of  
3           claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

4           **d.**     Failing and refusing to provide an explanation for the  
5           denial of benefits, payments or reimbursements of claims of each of  
6           the Patients, and by failing and refusing to set forth the specific reasons  
7           for such denials, all in violation of 29 U.S.C. § 1133(1);

8           **e.**     Failing and refusing to provide an explanation for the  
9           denial of benefits, payments or reimbursements of claims of each of  
10          the Patients, written in a manner calculated to be understood by the  
11          participant, in violation of 29 U.S.C. § 1133(1);

12          **f.**     Failing to afford Plaintiff and/or its Patients with a  
13          reasonable opportunity to engage in an appeals process, in violation of  
14          29 U.S.C. § 1133(2); Failing to afford Plaintiff and/or its Patients with  
15          a reasonable opportunity to engage in meaningful appeal process  
16          which was full and fair, in violation of 29 U.S.C. § 1133(2) Failing and  
17          refusing to provide Plaintiff and/or its Patients with information  
18          pertaining to their rights to appeal, including not limited to those  
19          deadlines for filing appeals and/or the requirements that an appeal be  
20          filed, in violation of 29 U.S.C. § 1133(1);

21          **g.**     Violating the minimum requirements for employee benefit  
22          plans pertaining to claims and benefits by participants and  
23          beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

24          **h.**     Failing and refusing to establish and maintain reasonable  
25          claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

26          **i.**     Establishing, maintaining and enforcing claims  
27          procedures which unduly inhibit the initiation and processing of claims  
28          for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);



1           **j.**     Precluding and prohibiting Plaintiff from acting as an  
2     authorized representative of the Patients in pursuing a benefit claim or  
3     appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
4     2560.503-1(b)(4);

5           **k.**     Failing and refusing to design, administer and enforce  
6     their processes, procedures and claims administration to ensure that  
7     their governing plan documents and provisions have been applied  
8     consistently with respect to similarly situated participants, beneficiaries  
9     and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

10          **l.**     Failing and refusing to pay benefits for authorized  
11     services rendered by Plaintiff;

12          **m.**     Failing to offer coverage for mental health and SUD  
13     treatment in parity with the medical and surgical benefits afforded by  
14     the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
15     mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

16          **n.**     Failing and refusing to pay Plaintiff for the SUD  
17     treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

18       **118.**    The failure and refusal of the United Healthcare Defendants to  
19    provide coverage, reimbursement, payment and/or benefits for the SUD and/or  
20    mental health treatment benefits rendered by Plaintiff to Plaintiff's patients who  
21    were covered by Defendants and Defendants' denial of health insurance benefits  
22    coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
23    between Defendants and Plaintiff's Patients. Plaintiff seeks reimbursement and  
24    compensation for any and all payments which it would have received and to which  
25    it will be entitled as a result of the United Healthcare Defendants' failure to pay  
26    benefits and cover those services rendered by Plaintiff to the Patients, in an amount  
27    not less than \$6,153,607.90, according to proof at trial.

1           **119.** Defendants have arbitrarily and capriciously breached the obligations  
2 set forth in the ERISA Plans issued by the United Healthcare Defendants, and the  
3 United Healthcare Defendants have arbitrarily and capriciously breached their  
4 obligations under the ERISA Plans to provide Plaintiff and the Patients with health  
5 benefits.

6           **120.** As a direct and proximate result of the actions by the United  
7 Healthcare Defendants, Plaintiff has been damaged in an amount equal to the  
8 amount of benefits Plaintiff should have received and to which the Patients would  
9 have been entitled had Defendants paid the proper amounts, which Plaintiff  
10 estimates to be \$6,153,607,190.

11           **121.** As a direct and proximate result of the aforesaid conduct of  
12 Defendants in failing to provide coverage as required, Plaintiff has suffered, and  
13 will continue to suffer in the future, damages, plus interest and other economic and  
14 consequential damages, for a total amount Plaintiff estimates to be \$6,153,909.9 or  
15 as otherwise determined at the time of trial.

16           **122.** Plaintiff is entitled to an award of statutory penalties against the  
17 United Healthcare Defendants.

18           **123.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
19 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the United  
20 Healthcare Defendants, Plaintiff has retained the services of legal counsel and has  
21 necessarily incurred attorneys' fees and costs in prosecuting this action.  
22 Furthermore, Plaintiff anticipates incurring additional attorneys' fees and costs  
23 hereafter pursuing this action.

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**SECOND CLAIM FOR RELIEF**

**(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B))**

**Against the BCBS KC)**

**124.** Plaintiff realleges and incorporates by reference each and every paragraph of this Complaint as though set forth herein.

**125.** Plaintiff is informed and believes, and based thereon alleges, that Morningside provided treatment for 1 patient insured for SUD and/or mental health treatment by BCBS KC under an ERISA Plan issued, underwritten and/or administrated by BCBS KC and/or the predecessor(s), assignor(s), agent(s), alter ego(s) or related entities of BCBS KC.

**126.** This claim is alleged by Plaintiff for relief in connection with claims for treatment rendered to members of an ERISA Plan. This claim seeks to recover benefits, enforce rights and clarify rights to benefits under 29 U.S.C. § 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the Patients' benefits under the ERISA Plans. As the assignee of benefits under the ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms of the ERISA Plans, and is the "claimant" for purposes of ERISA.

**127.** Plaintiff is informed and believes, and based thereon alleges, that BCBS KC is the insurer, sponsor, and/or financially responsible payer, serve as a designated plan administrator, and/or services as the named plan administrator's designee. Plaintiff is further informed and believes, and based thereon alleges, that with respect to each of the ERISA Plans at issue in this case that are self-insured plans, but which do not specifically designate a plan administrator, BCBS KC effectively controls the decision whether to honor or deny the a claim under the Plan, exercise authority over the resolution of benefits claims, and/or have responsibility to pay the claims. BCBS KC also plays the role as the *de facto* plan administrator for such ERISA Plans.

1       **128.** To date, there remains a balance due and owing by BCBS KC to  
2 Plaintiff in the amount of \$107,259.45. The individual patient claims relating to  
3 BCBS KC include the following: patient RP, with a balance due and owing to  
4 Plaintiff in the amount of \$107,259.45. This patient had a Preferred-Care Blue  
5 plan (the “**RP BCBS KC Plan**”). As required under the ACA and ERISA, the RP  
6 BCBS KC Plan must provide plan benefits for SUD and/or mental health treatment  
7 at no less than the amount required by law of UCR, notwithstanding patient copay  
8 and deductible obligations as set forth in the plan documents.

9       **129.** Plaintiff is informed and believes, and based thereon alleges, that for  
10 each of these claims and for each of the involved Patients, BCBS KC has failed  
11 and refused to pay, process or adjust these claims in an appropriate fashion by,  
12 among other acts and omissions:

13           **a.**       Delaying the processing, adjustment and/or payment of  
14 claims for periods of time greater than 45 days after submission of the  
15 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

16           **b.**       Failing and refusing to provide any notice and/or  
17 explanation for the denial of benefits, payments or reimbursement of  
18 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

19           **c.**       Failing and refusing to provide an adequate notice and/or  
20 explanation for the denial of benefits, payments or reimbursement of  
21 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

22           **d.**       Failing and refusing to provide an explanation for the  
23 denial of benefits, payments or reimbursements of claims of each of  
24 the Patients, and by failing and refusing to set forth the specific reasons  
25 for such denials, all in violation of 29 U.S.C. § 1133(1);

26           **e.**       Failing and refusing to provide an explanation for the  
27 denial of benefits, payments or reimbursements of claims of each of  
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1 the Patients, written in a manner calculated to be understood by the  
2 participant, in violation of 29 U.S.C. § 1133(1);

3 **f.** Failing to afford Plaintiff and/or its Patients with a  
4 reasonable opportunity to engage in an appeals process, in violation of  
5 29 U.S.C. § 1133(2);

6 **g.** Failing to afford Plaintiff and/or its Patients with a  
7 reasonable opportunity to engage in meaningful appeal process which  
8 was full and fair, in violation of 29 U.S.C. § 1133(2);

9 **h.** Failing and refusing to provide Plaintiff and/or its Patients  
10 with information pertaining to their rights to appeal, including not  
11 limited to those deadlines for filing appeals and/or the requirements  
12 that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

13 **i.** Violating the minimum requirements for employee benefit  
14 plans pertaining to claims and benefits by participants and  
15 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

16 **j.** Failing and refusing to establish and maintain reasonable  
17 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

18 **k.** Establishing, maintaining and enforcing claims  
19 procedures which unduly inhibit the initiation and processing of claims  
20 for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

21 **l.** Precluding and prohibiting Plaintiff from acting as an  
22 authorized representative of the Patients in pursuing a benefit claim or  
23 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
24 2560.503-1(b)(4);

25 **m.** Failing and refusing to design, administer and enforce  
26 their processes, procedures and claims administration to ensure that  
27 their governing plan documents and provisions have been applied  
28

1 consistently with respect to similarly situated participants, beneficiaries  
2 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

3 n. Failing and refusing to pay benefits for authorized  
4 services rendered by Plaintiff;

5 o. Failing to offer coverage for mental health and SUD  
6 treatment in parity with the medical and surgical benefits afforded by  
7 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
8 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

9 p. Failing and refusing to pay Plaintiff for the SUD  
10 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

11 **130.** The failure and refusal of BCBS KC to provide coverage,  
12 reimbursement, payment and/or benefits for the SUD and/or mental health  
13 treatment benefits rendered by Morningside to Plaintiff's patients who were  
14 covered by BCBS KC and BCBK KC's denial of health insurance benefits  
15 coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
16 between BCBS KC and the Patients at issue in this lawsuit.

17 **131.** BCBS KC has arbitrarily and capriciously breached the obligations set  
18 forth in the ERISA Plans issued by BCBS KC and BCBS KC has arbitrarily and  
19 capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
20 and that as a direct and proximate result of the actions by Defendants, Plaintiff has  
21 been damaged in an amount equal to the amount of benefits Plaintiff should have  
22 received and to which the Patients would have been entitled had BCBS KC paid  
23 the proper amounts, which Plaintiff estimates to be \$107,259.45.

24 **132.** As a direct and proximate result of the aforesaid conduct of BCBS KC  
25 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
26 to suffer in the future, damages, plus interest and other economic and  
27 consequential damages, for a total amount Plaintiff estimates to be \$107,259.45, or  
28 as otherwise determined at the time of trial.

1       **133.** Plaintiff is entitled to an award of statutory penalties in the amount to  
2 be determined at the time of trial against BCBS KC.

3       **134.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
4 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the BCBS KC,  
5 Plaintiff has retained the services of legal counsel and has necessarily incurred  
6 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
7 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
8 action

9                               **THIRD CLAIM FOR RELIEF**

10                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

11                               **Against the BCBS KI)**

12       **135.** Plaintiff realleges and incorporates by reference each and every  
13 paragraph of this Complaint as though set forth herein.

14       **136.** Plaintiff is informed and believes, and based thereon alleges, that  
15 Morningside provided treatment for patients insured for SUD and/or mental health  
16 treatment by BCBS KI under an ERISA Plan issued, underwritten and/or  
17 administrated by BCBS KI and/or the predecessor(s), assignor(s), agent(s), alter  
18 ego(s) or related entities of BCBS KI.

19       **137.** This claim is alleged by Plaintiff for relief in connection with claims  
20 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
21 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
22 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
23 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
24 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
25 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

26       **138.** Plaintiff is informed and believes, and based thereon alleges, that  
27 BCBS KI is the insurer, sponsor, and/or financially responsible payer, serve as a  
28 designated plan administrator, and/or services as the named plan administrator's



1 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
2 with respect to each of the ERISA Plans at issue in this case that are self-insured  
3 plans, but which do not specifically designate a plan administrator, BCBS KI  
4 effectively controls the decision whether to honor or deny the a claim under the  
5 Plan, exercise authority over the resolution of benefits claims, and/or have  
6 responsibility to pay the claims. BCBS KI also plays the role as the *de facto* plan  
7 administrator for such ERISA Plans.

8 **139.** With respect to the ERISA Plans relating to BCBS KI, Plaintiff's  
9 claims against BCBS KI include 5 separate patients of Morningside. To date, there  
10 remains a balance due and owing by BCBS KI to Plaintiff in the amount of  
11 \$475,043.94.

12 **140.** The individual patient claims relating to BCBS KI include the  
13 following:

14 **a.** Patient MA, with a balance due and owing to Plaintiff in the  
15 amount of \$39,000.00. This patient had an Individual Business plan (the  
16 "**MA BCBS KI Plan**"). As required under the ACA and ERISA, the MA  
17 BCBS KI Plan must provide plan benefits for SUD and/or mental health  
18 treatment at no less than the amount required by law of UCR,  
19 notwithstanding patient copay and deductible obligations as set forth in the  
20 plan documents.

21 **b.** Patient SH, with a balance due and owing to Plaintiff in the  
22 amount of \$27,083.62. This patient had the Twin Motors Ford, Inc. plan  
23 (the "**SH BCBS KI Plan**"). As required under the ACA and ERISA, the SH  
24 BCBS KI Plan must provide plan benefits for SUD and/or mental health  
25 treatment at no less than the amount required by law of UCR,  
26 notwithstanding patient copay and deductible obligations as set forth in the  
27 plan documents.  
28

1           c.     Patient TJ, with a balance due and owing to Plaintiff in the  
2     amount of \$26,106.84. This patient had a Minneola Cooperative, Inc. plan  
3     (the “**TJ BCBS KI Plan**”). As required under the ACA and ERISA, the TJ  
4     BCBS KI Plan must provide plan benefits for SUD and/or mental health  
5     treatment at no less than the amount required by law of UCR,  
6     notwithstanding patient copay and deductible obligations as set forth in the  
7     plan documents.

8           d.     Patient BMc, with a balance due and owing to Plaintiff in the  
9     amount of \$270,242.44. This patient had the Big Bins Mini Storage plan  
10    (the “**BMc BCBS KI Plan**”). As required under the ACA and ERISA, the  
11    BMc BCBS KI Plan must provide plan benefits for SUD and/or mental  
12    health treatment at no less than the amount required by law of UCR,  
13    notwithstanding patient copay and deductible obligations as set forth in the  
14    plan documents.

15          e.     Patient BM, with a balance due and owing to Plaintiff in the  
16    amount of \$112,611.04. This patient had the Individual Business plan (the  
17    “**BM BCBS KI Plan**”). As required under the ACA and ERISA, the BM  
18    BCBS KI Plan must provide plan benefits for SUD and/or mental health  
19    treatment at no less than the amount required by law of UCR,  
20    notwithstanding patient copay and deductible obligations as set forth in the  
21    plan documents.

22          f.     The MA BCBS KI Plan, the SH BCBS KI Plan, the TJ BCBS  
23    KI Plan, the Bmc BCBS KI Plan, and the BM BCBS KI Plan shall  
24    sometimes be referred to collectively as the “**BCBS KI Plans**” copay and  
25    deductible obligations as set forth in the plan documents.

26          **141.** Plaintiff is informed and believes, and based thereon alleges, that for  
27    each of these claims and for each of the involved Patients, BCBS KI has failed and  
28

1 refused to pay, process or adjust these claims in an appropriate fashion by, among  
2 other acts and omissions:

3           **a.**     Delaying the processing, adjustment and/or payment of  
4 claims for periods of time greater than 45 days after submission of the  
5 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

6           **b.**     Failing and refusing to provide any notice and/or  
7 explanation for the denial of benefits, payments or reimbursement of  
8 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

9           **c.**     Failing and refusing to provide an adequate notice and/or  
10 explanation for the denial of benefits, payments or reimbursement of  
11 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

12           **d.**     Failing and refusing to provide an explanation for the  
13 denial of benefits, payments or reimbursements of claims of each of  
14 the Patients, and by failing and refusing to set forth the specific reasons  
15 for such denials, all in violation of 29 U.S.C. § 1133(1);

16           **e.**     Failing and refusing to provide an explanation for the  
17 denial of benefits, payments or reimbursements of claims of each of  
18 the Patients, written in a manner calculated to be understood by the  
19 participant, in violation of 29 U.S.C. § 1133(1);

20           **f.**     Failing to afford Plaintiff and/or its Patients with a  
21 reasonable opportunity to engage in an appeals process, in violation of  
22 29 U.S.C. § 1133(2);

23           **g.**     Failing to afford Plaintiff and/or its Patients with a  
24 reasonable opportunity to engage in meaningful appeal process which  
25 was full and fair, in violation of 29 U.S.C. § 1133(2);

26           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
27 with information pertaining to their rights to appeal, including not  
28

1 limited to those deadlines for filing appeals and/or the requirements  
2 that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

3 **i.** Violating the minimum requirements for employee benefit  
4 plans pertaining to claims and benefits by participants and  
5 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

6 **j.** Failing and refusing to establish and maintain reasonable  
7 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

8 **k.** Establishing, maintaining and enforcing claims  
9 procedures which unduly inhibit the initiation and processing of claims  
10 for benefits, in violation of 29 C.F.R. § 2560.503-1(b)(3);

11 **l.** Precluding and prohibiting Plaintiff from acting as an  
12 authorized representative of the Patients in pursuing a benefit claim or  
13 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
14 2560.503-1(b)(4);

15 **m.** Failing and refusing to design, administer and enforce  
16 their processes, procedures and claims administration to ensure that  
17 their governing plan documents and provisions have been applied  
18 consistently with respect to similarly situated participants, beneficiaries  
19 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

20 **n.** Failing and refusing to pay benefits for authorized  
21 services rendered by Plaintiff;

22 **o.** Failing to offer coverage for mental health and SUD  
23 treatment in parity with the medical and surgical benefits afforded by  
24 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
25 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

26 **p.** Failing and refusing to pay Plaintiff for the SUD  
27 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).  
28

1           **142.** The failure and refusal of BCBS KI to provide coverage,  
2 reimbursement, payment and/or benefits for the SUD and/or mental health  
3 treatment benefits rendered by Morningside to Plaintiff's patients who were  
4 covered by BCBS KI and BCBK KI's denial of health insurance benefits coverage  
5 constitutes a breach of the insurance plans and/or employee benefit Plans between  
6 BCBS KI and the Patients at issue in this lawsuit.

7           **143.** BCBS KI has arbitrarily and capriciously breached the obligations set  
8 forth in the ERISA Plans issued by BCBS KI and BCBS KI has arbitrarily and  
9 capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
10 and that as a direct and proximate result of the actions by BCBS KI, Plaintiff has  
11 been damaged in an amount equal to the amount of benefits Plaintiff should have  
12 received and to which the Patients would have been entitled had BCBS KI paid the  
13 proper amounts, which Plaintiff estimates to be \$475,043.94.

14           **144.** As a direct and proximate result of the aforesaid conduct of BCBS KI  
15 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
16 to suffer in the future, damages, plus interest and other economic and  
17 consequential damages, for a total amount Plaintiff estimates to be \$475,043.94, or  
18 as otherwise determined at the time of trial.

19           **145.** Plaintiff is entitled to an award of statutory penalties in the amount to  
20 be determined at the time of trial against BCBS KI.

21           **146.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
22 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the BCBS KI,  
23 Plaintiff has retained the services of legal counsel and has necessarily incurred  
24 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
25 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
26 action.

**FOURTH CLAIM FOR RELIEF**

**(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

**Against the BCBS Miss)**

**147.** Plaintiff realleges and incorporates by reference each and every paragraph of this Complaint as though set forth herein.

**148.** Plaintiff is informed and believes, and based thereon alleges, that Morningside provided treatment for patients insured for SUD and/or mental health treatment by BCBS Miss under an ERISA Plan issued, underwritten and/or administrated by BCBS Miss and/or the predecessor(s), assignor(s), agent(s), alter ego(s) or related entities of BCBS Miss.

**149.** This claim is alleged by Plaintiff for relief in connection with claims for treatment rendered to members of an ERISA Plan. This claim seeks to recover benefits, enforce rights and clarify rights to benefits under 29 U.S.C. § 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the Patients' benefits under the ERISA Plans. As the assignee of benefits under the ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms of the ERISA Plans, and is the "claimant" for purposes of ERISA.

**150.** Plaintiff is informed and believes, and based thereon alleges, that BCBS Miss is the insurer, sponsor, and/or financially responsible payer, serve as a designated plan administrator, and/or services as the named plan administrator's designee. Plaintiff is further informed and believes, and based thereon alleges, that with respect to each of the ERISA Plans at issue in this case that are self-insured plans, but which do not specifically designate a plan administrator, BCBS Miss effectively controls the decision whether to honor or deny the a claim under the Plan, exercise authority over the resolution of benefits claims, and/or have responsibility to pay the claims. BCBS Miss also plays the role as the *de facto* plan administrator for such ERISA Plans.

1       **151.** With respect to the ERISA Plans relating to BCBS Miss, Plaintiff's  
2 claims against BCBS Miss include 3 separate patients of Morningside. To date,  
3 there remains a balance due and owing by BCBS Miss to Plaintiff in the amount of  
4 \$259,828.34.

5       **152.** The individual patient claims relating to BCBS Miss include the  
6 following:

7           **a.** Patient DD, with a balance due and owing to Plaintiff in the  
8 amount of \$188,490.54. This patient had a (redacted) plan (the "**DD BCBS**  
9 **Miss Plan**"). As required under the ACA and ERISA, the DD BCBS Miss  
10 Plan must provide plan benefits for SUD and/or mental health treatment at  
11 no less than the amount required by law of UCR, notwithstanding patient  
12 copay and deductible obligations as set forth in the plan documents.

13           **b.** Patient JH, with a balance due and owing to Plaintiff in the  
14 amount of \$5,772.67. This patient had the Partridge-Sibley Industrial  
15 Services, Inc. plan (the "**JH BCBS Miss Plan**"). As required under the  
16 ACA and ERISA, the JH BCBS Miss Plan must provide plan benefits for  
17 SUD and/or mental health treatment at no less than the amount required by  
18 law of UCR, notwithstanding patient copay and deductible obligations as set  
19 forth in the plan documents.

20           **c.** Patient RM, with a balance due and owing to Plaintiff in the  
21 amount of \$65,565.13. BCBS Miss has not provided information to Plaintiff  
22 whether the above-referenced BCBS Miss patient at issue falls under an  
23 ERISA plan or not, so in an abundance of caution, Plaintiff lists all claims at  
24 this time.

25           **d.** The DD BCBS Miss Plan and the JH BCBS Miss Plan shall  
26 sometimes be referred to collectively as the "**BCBS Miss Plans**"

27       **153.** Plaintiff is informed and believes, and based thereon alleges, that for  
28 each of these claims and for each of the involved Patients, BCBS Miss has failed



1 and refused to pay, process or adjust these claims in an appropriate fashion by,  
2 among other acts and omissions:

3           **a.**     Delaying the processing, adjustment and/or payment of  
4           claims for periods of time greater than 45 days after submission of the  
5           claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

6           **b.**     Failing and refusing to provide any notice and/or  
7           explanation for the denial of benefits, payments or reimbursement of  
8           the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

9           **c.**     Failing and refusing to provide an adequate notice and/or  
10          explanation for the denial of benefits, payments or reimbursement of  
11          claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

12          **d.**     Failing and refusing to provide an explanation for the  
13          denial of benefits, payments or reimbursements of claims of each of  
14          the Patients, and by failing and refusing to set forth the specific reasons  
15          for such denials, all in violation of 29 U.S.C. § 1133(1);

16          **e.**     Failing and refusing to provide an explanation for the  
17          denial of benefits, payments or reimbursements of claims of each of  
18          the Patients, written in a manner calculated to be understood by the  
19          participant, in violation of 29 U.S.C. § 1133(1);

20          **f.**     Failing to afford Plaintiff and/or its Patients with a  
21          reasonable opportunity to engage in an appeals process, in violation of  
22          29 U.S.C. § 1133(2);

23          **g.**     Failing to afford Plaintiff and/or its Patients with a  
24          reasonable opportunity to engage in meaningful appeal process which  
25          was full and fair, in violation of 29 U.S.C. § 1133(2);

26          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
27          with information pertaining to their rights to appeal, including not  
28

1 limited to those deadlines for filing appeals and/or the requirements  
2 that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

3 **i.** Violating the minimum requirements for employee benefit  
4 plans pertaining to claims and benefits by participants and  
5 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

6 **j.** Failing and refusing to establish and maintain reasonable  
7 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

8 **k.** Establishing, maintaining and enforcing claims  
9 procedures which unduly inhibit the initiation and processing of claims  
10 for benefits, in violation of 29 C.F.R. § 2560.503-1(b)(3);

11 **l.** Precluding and prohibiting Plaintiff from acting as an  
12 authorized representative of the Patients in pursuing a benefit claim or  
13 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
14 2560.503-1(b)(4);

15 **m.** Failing and refusing to design, administer and enforce  
16 their processes, procedures and claims administration to ensure that  
17 their governing plan documents and provisions have been applied  
18 consistently with respect to similarly situated participants, beneficiaries  
19 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

20 **n.** Failing and refusing to pay benefits for authorized  
21 services rendered by Plaintiff;

22 **o.** Failing to offer coverage for mental health and SUD  
23 treatment in parity with the medical and surgical benefits afforded by  
24 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
25 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

26 **p.** Failing and refusing to pay Plaintiff for the SUD  
27 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).  
28

1           **154.** The failure and refusal of BCBS Miss to provide coverage,  
2 reimbursement, payment and/or benefits for the SUD and/or mental health  
3 treatment benefits rendered by Morningside to Plaintiff's patients who were  
4 covered by BCBS Miss and BCBS Miss's denial of health insurance benefits  
5 coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
6 between BCBS Miss and the Patients at issue in this lawsuit.

7           **155.** BCBS Miss has arbitrarily and capriciously breached the obligations  
8 set forth in the ERISA Plans issued by BCBS Miss and BCBS Miss has arbitrarily  
9 and capriciously breached their obligations under the ERISA Plans to provide  
10 Plaintiff and that as a direct and proximate result of the actions by Defendants,  
11 Plaintiff has been damaged in an amount equal to the amount of benefits Plaintiff  
12 should have received and to which the Patients would have been entitled had  
13 BCBS Miss paid the proper amounts, which Plaintiff estimates to be \$259,828.34.

14           **156.** As a direct and proximate result of the aforesaid conduct of BCBS  
15 Miss in failing to provide coverage as required, Plaintiff has suffered, and will  
16 continue to suffer in the future, damages, plus interest and other economic and  
17 consequential damages, for a total amount Plaintiff estimates to be \$259,828.34, or  
18 as otherwise determined at the time of trial.

19           **157.** Plaintiff is entitled to an award of statutory penalties in the amount to  
20 be determined at the time of trial against BCBS Miss.

21           **158.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
22 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the BCBS  
23 Miss, Plaintiff has retained the services of legal counsel and has necessarily  
24 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
25 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
26 action.

**FIFTH CLAIM FOR RELIEF**

**(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

**Against BCBS Ok)**

**159.** Plaintiff realleges and incorporates by reference each and every paragraph of this Complaint as though set forth herein.

**160.** This claim is alleged by Plaintiff for relief in connection with claims for treatment rendered to members of an ERISA Plan. This claim seeks to recover benefits, enforce rights and clarify rights to benefits under 29 U.S.C. § 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the Patients' benefits under the ERISA Plans. As the assignee of benefits under the ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms of the ERISA Plans, and is the "claimant" for purposes of ERISA.

**161.** Plaintiff is informed and believes, and based thereon alleges, that BCBS Ok is the insurer, sponsor, and/or financially responsible payer, serve as a designated plan administrator, and/or services as the named plan administrator's designee. Plaintiff is further informed and believes, and based thereon alleges, that with respect to each of the ERISA Plans at issue in this case that are self-insured plans, but which do not specifically designate a plan administrator, BCBS Ok effectively controls the decision whether to honor or deny a claim under the Plan, exercise authority over the resolution of benefits claims, and/or have responsibility to pay the claims. BCBS Ok also plays the role as the *de facto* plan administrator for such ERISA Plans.

**162.** With respect to the ERISA Plans relating to BCBS Ok, Plaintiff's claims against BCBS Ok include 4 separate patients of Morningside. To date, there remains a balance due and owing by BCBS Ok to Plaintiff in the amount of \$362,679.51.

**163.** The individual patient claims relating to BCBS Ok include the following:

1           a. Patient CB, with a balance due and owing to Plaintiff in the  
2 amount of \$100,955.79. This patient had a Blue Advantage Gold PPO 102  
3 plan with the Blue Advantage PPO Network (the “**CB BCBS Ok Plan**”).  
4 As required under the ACA and ERISA, the CB BCBS Ok Plan must  
5 provide plan benefits for SUD and/or mental health treatment at no less than  
6 the amount required by law of UCR, notwithstanding patient copay and  
7 deductible obligations as set forth in the plan documents.

8           b. Patient MF, with a balance due and owing to Plaintiff in the  
9 amount of \$1,396.30. This patient had a Blue Choice Gold PPO 201 plan  
10 with the Blue Choice PPO Network (the “**MF BCBS Ok Plan**”). As  
11 required under the ACA and ERISA, the MF BCBS Ok Plan must provide  
12 plan benefits for SUD and/or mental health treatment at no less than the  
13 amount required by law of UCR, notwithstanding patient copay and  
14 deductible obligations as set forth in the plan documents.

15           c. Patient RW, with a balance due and owing to Plaintiff in the  
16 amount of \$45,098.56. This patient had a Blue Choice Silver PPO 003 plan  
17 with the Blue Choice PPO Network (the “**RW BCBS Ok Plan**”). As  
18 required under the ACA and ERISA, the RW BCBS Ok Plan must provide  
19 plan benefits for SUD and/or mental health treatment at no less than the  
20 amount required by law of UCR, notwithstanding patient copay and  
21 deductible obligations as set forth in the plan documents.

22           d. Patient MZ, with a balance due and owing to Plaintiff in the  
23 amount of \$215,228.86. This patient had a Blue Advantage Silver PPO 111  
24 plan with the Blue Advantage PPO Network (the “**MZ BCBS Ok Plan**”).  
25 As required under the ACA and ERISA, the MZ BCBS Ok Plan must  
26 provide plan benefits for SUD and/or mental health treatment at no less than  
27 the amount required by law of UCR, notwithstanding patient copay and  
28 deductible obligations as set forth in the plan documents.

1           e.     The CB BCBS Ok Plan, the MF BCBS Ok Plan, the RW BCBS  
2     Ok Plan and the MZ BCBS Ok Plan shall sometimes be referred to  
3     collectively as the “**BCBS Ok Plans**”.

4     **164.** Plaintiff is informed and believes, and based thereon alleges, that for  
5     each of these claims and for each of the involved Patients, BCBS Ok has failed and  
6     refused to pay, process or adjust these claims in an appropriate fashion by, among  
7     other acts and omissions:

8           a.     Delaying the processing, adjustment and/or payment of  
9     claims for periods of time greater than 45 days after submission of the  
10    claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

11          b.     Failing and refusing to provide any notice and/or  
12    explanation for the denial of benefits, payments or reimbursement of  
13    the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

14          c.     Failing and refusing to provide an adequate notice and/or  
15    explanation for the denial of benefits, payments or reimbursement of  
16    claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

17          d.     Failing and refusing to provide an explanation for the  
18    denial of benefits, payments or reimbursements of claims of each of  
19    the Patients, and by failing and refusing to set forth the specific reasons  
20    for such denials, all in violation of 29 U.S.C. § 1133(1);

21          e.     Failing and refusing to provide an explanation for the  
22    denial of benefits, payments or reimbursements of claims of each of  
23    the Patients, written in a manner calculated to be understood by the  
24    participant, in violation of 29 U.S.C. § 1133(1);

25          f.     Failing to afford Plaintiff and/or its Patients with a  
26    reasonable opportunity to engage in an appeals process, in violation of  
27    29 U.S.C. § 1133(2);  
28

1           **g.**     Failing to afford Plaintiff and/or its Patients with a  
2     reasonable opportunity to engage in meaningful appeal process which  
3     was full and fair, in violation of 29 U.S.C. § 1133(2);

4           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
5     with information pertaining to their rights to appeal, including not  
6     limited to those deadlines for filing appeals and/or the requirements  
7     that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

8           **i.**     Violating the minimum requirements for employee benefit  
9     plans pertaining to claims and benefits by participants and  
10    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

11          **j.**     Failing and refusing to establish and maintain reasonable  
12    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

13          **k.**     Establishing, maintaining and enforcing claims  
14    procedures which unduly inhibit the initiation and processing of claims  
15    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

16          **l.**     Precluding and prohibiting Plaintiff from acting as an  
17    authorized representative of the Patients in pursuing a benefit claim or  
18    appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
19    2560.503-1(b)(4);

20          **m.**     Failing and refusing to design, administer and enforce  
21    their processes, procedures and claims administration to ensure that  
22    their governing plan documents and provisions have been applied  
23    consistently with respect to similarly situated participants, beneficiaries  
24    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

25          **n.**     Failing and refusing to pay benefits for authorized  
26    services rendered by Plaintiff;

27          **o.**     Failing to offer coverage for mental health and SUD  
28    treatment in parity with the medical and surgical benefits afforded by



1 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
2 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

3 **p.** Failing and refusing to pay Plaintiff for the SUD  
4 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

5 **165.** The failure and refusal of BCBS Ok to provide coverage,  
6 reimbursement, payment and/or benefits for the SUD and/or mental health  
7 treatment benefits rendered by Morningside to Plaintiff's patients who were  
8 covered by BCBS Ok and BCBK Ok's denial of health insurance benefits coverage  
9 constitutes a breach of the insurance plans and/or employee benefit Plans between  
10 BCBS Ok and the Patients at issue in this lawsuit.

11 **166.** BCBS Ok has arbitrarily and capriciously breached the obligations set  
12 forth in the ERISA Plans issued by BCBS Ok and BCBS Ok has arbitrarily and  
13 capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
14 and that as a direct and proximate result of the actions by Defendants, Plaintiff has  
15 been damaged in an amount equal to the amount of benefits Plaintiff should have  
16 received and to which the Patients would have been entitled had BCBS Ok paid the  
17 proper amounts, which Plaintiff estimates to be \$362,679.51.

18 **167.** As a direct and proximate result of the aforesaid conduct of BCBS Ok  
19 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
20 to suffer in the future, damages, plus interest and other economic and  
21 consequential damages, for a total amount Plaintiff estimates to be \$362,679.51, or  
22 as otherwise determined at the time of trial.

23 **168.** Plaintiff is entitled to an award of statutory penalties in the amount to  
24 be determined at the time of trial against BCBS Ok.

25 **169.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
26 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the BCBS Ok,  
27 Plaintiff has retained the services of legal counsel and has necessarily incurred  
28 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff

1 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
2 action.

3 **SIXTH CLAIM FOR RELIEF**

4 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

5 **Against the Humana Defendants)**

6 **170.** Plaintiff realleges and incorporates by reference each and every  
7 paragraph of this Complaint as though set forth herein.

8 **171.** This claim is alleged by Plaintiff for relief in connection with claims  
9 for treatment rendered to members of ERISA Plans. This claim seeks to recover  
10 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
11 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
12 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
13 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
14 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

15 **172.** Plaintiff is informed and believes, and based thereon alleges, that the  
16 Humana Defendants are the insurer, sponsor, and/or financially responsible payer,  
17 serve as a designated plan administrator, and/or services as the named plan  
18 administrator's designee. Plaintiff is further informed and believes, and based  
19 thereon alleges, that with respect to each of the ERISA Plans at issue in this case  
20 that are self-insured plans, but which do not specifically designate a plan  
21 administrator, the Humana Defendants effectively control the decision whether to  
22 honor or deny the a claim under the ERISA Plans, exercise authority over the  
23 resolution of benefits claims, and/or have responsibility to pay the claims. The  
24 Humana Defendants also play the role as the *de facto* plan administrator for such  
25 ERISA Plans.

26 **173.** With respect to the ERISA Plans relating to the Humana Defendants,  
27 Plaintiff's claims against the Humana Defendants include 25 separate patients of  
28

1 Morningside. To date, there remains a balance due and owing by the Humana  
2 Defendants to Plaintiff in the amount of \$1,794,394.00.

3 **174.** The individual patient claims relating to the Humana Defendants  
4 include the following:

5 **a.** Patient JB, with a balance due and owing to Plaintiff in the  
6 amount of \$104,322.26. This patient had a PPO plan with the Humana  
7 Network (the “**JB Humana Plan**”). As required under the ACA and  
8 ERISA, the JB Humana Plan must provide plan benefits for SUD and/or  
9 mental health treatment at no less than the amount required by law of UCR,  
10 notwithstanding patient copay and deductible obligations as set forth in the  
11 plan documents.

12 **b.** Patient AB, with a balance due and owing to Plaintiff in the  
13 amount of \$99,440.75. This patient had a USAA Medical Care  
14 Program/Humana Insurance Company plan with the Humana Network (the  
15 “**AB Humana Plan**”). As required under the ACA and ERISA, the AB  
16 Humana Plan must provide plan benefits for SUD and/or mental health  
17 treatment at no less than the amount required by law of UCR,  
18 notwithstanding patient copay and deductible obligations as set forth in the  
19 plan documents.

20 **c.** Patient KB, with a balance due and owing to Plaintiff in the  
21 amount of \$191,712.63. This patient had a Humana Insurance Company and  
22 Humana Employers Health Plan of Georgia, Inc. plan with the Humana  
23 Network (the “**KB Humana Plan**”). As required under the ACA and  
24 ERISA, the KB Humana Plan must provide plan benefits for SUD and/or  
25 mental health treatment at no less than the amount required by law of UCR,  
26 notwithstanding patient copay and deductible obligations as set forth in the  
27 plan documents.  
28

1           d.     Patient BC, with a balance due and owing to Plaintiff in the  
2     amount of \$11,536.11. This patient had a Humana Insurance Company plan  
3     with the Humana Network plan with the Humana Network (the “**BC**  
4     **Humana Plan**”). As required under the ACA and ERISA, the BC Humana  
5     Plan must provide plan benefits for SUD and/or mental health treatment at  
6     no less than the amount required by law of UCR, notwithstanding patient  
7     copay and deductible obligations as set forth in the plan documents.

8           e.     Patient RC, with a balance due and owing to Plaintiff in the  
9     amount of \$71,032.04. This patient had a Humana Insurance Company and  
10    Humana Employers Health Plan of Georgia, Inc. with the Humana Network  
11    (the “**RC Humana Plan**”). As required under the ACA and ERISA, the RC  
12    Humana Plan must provide plan benefits for SUD and/or mental health  
13    treatment at no less than the amount required by law of UCR,  
14    notwithstanding patient copay and deductible obligations as set forth in the  
15    plan documents.

16          f.     Patient MD, with a balance due and owing to Plaintiff in the  
17    amount of \$74,351. This patient had a Humana Insurance Company and  
18    Humana Employers Health Plan of Georgia, Inc. with the Humana Network  
19    (the “**MD Humana Plan**”). As required under the ACA and ERISA, the  
20    MD Humana Plan must provide plan benefits for SUD and/or mental health  
21    treatment at no less than the amount required by law of UCR,  
22    notwithstanding patient copay and deductible obligations as set forth in the  
23    plan documents.

24          g.     Patient DD, with a balance due and owing to Plaintiff in the  
25    amount of \$94,225.28. This patient had a Humana Health Plan of Texas,  
26    Inc. Plan with the Humana Network (the “**DD Humana Plan**”). As required  
27    under the ACA and ERISA, the DD Humana Plan must provide plan  
28    benefits for SUD and/or mental health treatment at no less than the amount

1 required by law of UCR, notwithstanding patient copay and deductible  
2 obligations as set forth in the plan documents.

3       **h.** Patient BG, with a balance due and owing to Plaintiff in the  
4 amount of \$122,166.70. This patient had a Humana Insurance Company  
5 Plan with the Humana Network (the “**BG Humana Plan**”). As required  
6 under the ACA and ERISA, the BG Humana Plan must provide plan benefits  
7 for SUD and/or mental health treatment at no less than the amount required  
8 by law of UCR, notwithstanding patient copay and deductible obligations as  
9 set forth in the plan documents.

10       **i.** Patient GG, with a balance due and owing to Plaintiff in the  
11 amount of \$31,655.00. This patient had a Humana Health Benefit Plan of  
12 Louisiana, Inc. Plan with the Humana Network (the “**GG Humana Plan**”).  
13 As required under the ACA and ERISA, the GG Humana Plan must provide  
14 plan benefits for SUD and/or mental health treatment at no less than the  
15 amount required by law of UCR, notwithstanding patient copay and  
16 deductible obligations as set forth in the plan documents.

17       **j.** Patient JJ, with a balance due and owing to Plaintiff in the  
18 amount of \$62,801.00. This patient had a Humana Health Plan, Inc. Plan  
19 with the Humana Network (the “**JJ Humana Plan**”). As required under the  
20 ACA and ERISA, the JJ Humana Plan must provide plan benefits for SUD  
21 and/or mental health treatment at no less than the amount required by law of  
22 UCR, notwithstanding patient copay and deductible obligations as set forth  
23 in the plan documents.

24       **k.** Patient MJ, with a balance due and owing to Plaintiff in the  
25 amount of \$76,076.06. This patient had a Humana Insurance Company Plan  
26 with the Humana Network (the “**MJ Humana Plan**”). As required under  
27 the ACA and ERISA, the MJ Humana Plan must provide plan benefits for  
28 SUD and/or mental health treatment at no less than the amount required by

1 law of UCR, notwithstanding patient copay and deductible obligations as set  
2 forth in the plan documents.

3 l. Patient LK, with a balance due and owing to Plaintiff in the  
4 amount of \$89,837.95. This patient had a Humana Insurance Company and  
5 Humana Employers Health Plan of Georgia, Inc. Plan with the Humana  
6 Network (the “**LK Humana Plan**”). As required under the ACA and  
7 ERISA, the LK Humana Plan must provide plan benefits for SUD and/or  
8 mental health treatment at no less than the amount required by law of UCR,  
9 notwithstanding patient copay and deductible obligations as set forth in the  
10 plan documents.

11 m. Patient LL, with a balance due and owing to Plaintiff in the  
12 amount of \$97,542.85. This patient had a Humana Health Benefit Plan of  
13 Louisiana, Inc. Plan with the Humana Network (the “**LL Humana Plan**”).  
14 As required under the ACA and ERISA, the LL Humana Plan must provide  
15 plan benefits for SUD and/or mental health treatment at no less than the  
16 amount required by law of UCR, notwithstanding patient copay and  
17 deductible obligations as set forth in the plan documents.

18 n. Patient AL, with a balance due and owing to Plaintiff in the  
19 amount of \$23,865.55. This patient had a Humana Insurance Company Plan  
20 with the Humana Network (the “**AL Humana Plan**”). As required under  
21 the ACA and ERISA, the AL Humana Plan must provide plan benefits for  
22 SUD and/or mental health treatment at no less than the amount required by  
23 law of UCR, notwithstanding patient copay and deductible obligations as set  
24 forth in the plan documents.

25 o. Patient TM, with a balance due and owing in the amount of  
26 \$30,000.00. This patient had a Humana Insurance Company Plan with the  
27 Humana Network (the “**TM Humana Plan**”). As required under the ACA  
28 and ERISA, the TM Humana Plan must provide plan benefits for SUD

1 and/or mental health treatment at no less than the amount required by law of  
2 UCR, notwithstanding patient copay and deductible obligations as set forth  
3 in the plan documents.

4 p. Patient JM, with a balance due and owing in the amount of  
5 \$23,160.00. This patient had a Humana Insurance Company Plan with the  
6 Humana Network (the “**JM Humana Plan**”). As required under the ACA  
7 and ERISA, the JM Humana Plan must provide plan benefits for SUD and/or  
8 mental health treatment at no less than the amount required by law of UCR,  
9 notwithstanding patient copay and deductible obligations as set forth in the  
10 plan documents.

11 q. Patient KMc, with a balance due and owing in the amount of  
12 \$23,040.00. This patient had a Humana Health Plan, Inc. Plan with the  
13 Humana Network (the “**KMc Humana Plan**”). As required under the ACA  
14 and ERISA, the KMc Humana Plan must provide plan benefits for SUD  
15 and/or mental health treatment at no less than the amount required by law of  
16 UCR, notwithstanding patient copay and deductible obligations as set forth  
17 in the plan documents.

18 r. Patient KR, with a balance due and owing in the amount of  
19 \$11,460.00. This patient had a Humana Insurance Company Plan with the  
20 Humana Network (the “**KR Humana Plan**”). As required under the ACA  
21 and ERISA, the KR Humana Plan must provide plan benefits for SUD  
22 and/or mental health treatment at no less than the amount required by law of  
23 UCR, notwithstanding patient copay and deductible obligations as set forth  
24 in the plan documents.

25 s. Patient JS, with a balance due and owing in the amount of  
26 \$40,285.55. This patient had a Humana Insurance Company Plan with the  
27 Humana Network (the “**JS Humana Plan**”). As required under the ACA  
28 and ERISA, the JS Humana Plan must provide plan benefits for SUD and/or



1 mental health treatment at no less than the amount required by law of UCR,  
2 notwithstanding patient copay and deductible obligations as set forth in the  
3 plan documents.

4 t. Patient ET, with a balance due and owing in the amount of  
5 \$106,072.28. This patient had a Humana Insurance Company Plan with the  
6 Humana Network (the “**ET Humana Plan**”). As required under the ACA  
7 and ERISA, the ET Humana Plan must provide plan benefits for SUD and/or  
8 mental health treatment at no less than the amount required by law of UCR,  
9 notwithstanding patient copay and deductible obligations as set forth in the  
10 plan documents.

11 u. Patient MT, with a balance due and owing in the amount of  
12 \$18,100.00. This patient had a Humana Insurance Company Plan with the  
13 Humana Network (the “**MT Humana Plan**”). As required under the ACA  
14 and ERISA, the MT Humana Plan must provide plan benefits for SUD  
15 and/or mental health treatment at no less than the amount required by law of  
16 UCR, notwithstanding patient copay and deductible obligations as set forth  
17 in the plan documents.

18 v. Patient SW, with a balance due and owing in the amount of  
19 \$61,103.58. This patient had a Humana Insurance Company and Humana  
20 Employers Health Plan of Georgia, Inc. Plan with the Humana Network (the  
21 “**SW Humana Plan**”). As required under the ACA and ERISA, the SW  
22 Humana Plan must provide plan benefits for SUD and/or mental health  
23 treatment at no less than the amount required by law of UCR,  
24 notwithstanding patient copay and deductible obligations as set forth in the  
25 plan documents.

26 w. Patient JW, with a balance due and owing in the amount of  
27 \$100,341.39. This patient had a Humana Insurance Company Plan with the  
28 Humana Network (the “**JW Humana Plan**”). As required under the ACA

1 and ERISA, the JW Humana Plan must provide plan benefits for SUD  
2 and/or mental health treatment at no less than the amount required by law of  
3 UCR, notwithstanding patient copay and deductible obligations as set forth  
4 in the plan documents.

5 x. Patient DW, with a balance due and owing in the amount of  
6 \$65,355.00. This patient had a Humana Health Plan, Inc. with the Humana  
7 Network (the “**DW Humana Plan**”). As required under the ACA and  
8 ERISA, the DW Humana Plan must provide plan benefits for SUD and/or  
9 mental health treatment at no less than the amount required by law of UCR,  
10 notwithstanding patient copay and deductible obligations as set forth in the  
11 plan documents.

12 y. Patient DY, with a balance due and owing in the amount of  
13 \$76,204.14. This patient had a Humana Insurance Company Plan with the  
14 Humana Network (the “**DY Humana Plan**”). As required under the ACA  
15 and ERISA, the DY Humana Plan must provide plan benefits for SUD  
16 and/or mental health treatment at no less than the amount required by law of  
17 UCR, notwithstanding patient copay and deductible obligations as set forth  
18 in the plan documents.

19 **175.** The JB Humana Plan, the AB Humana Plan, the KB Humana Plan,  
20 the BC Humana Plan, the RC Humana Plan, the MD Humana Plan, the DD  
21 Humana Plan, the BG Humana Plan, the GG Humana Plan, the JJ Humana Plan,  
22 the MJ Humana Plan, the LK Humana Plan, the LL Humana Plan, the AL Humana  
23 Plan, the TM Humana Plan, the JM Humana Plan, the KMc Humana Plan, the KR  
24 Humana Plan, the JS Humana Plan, the ET Humana Plan, the MT Humana Plan,  
25 the SW Humana Plan, the MW Humana Plan, the JW Humana Plan, the DW  
26 Humana Plan, and the DY Humana Plan shall sometimes be referred to collectively  
27 as the “**Humana Plans**”.

1       **176.** Plaintiff is informed and believes, and based thereon alleges, that for  
2 each of these claims and for each of the involved Patients, the Humana Defendants  
3 have failed and refused to pay, process or adjust these claims in an appropriate  
4 fashion by, among other acts and omissions:

5               **a.**       Delaying the processing, adjustment and/or payment of  
6 claims for periods of time greater than 45 days after submission of the  
7 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

8               **b.**       Failing and refusing to provide any notice and/or  
9 explanation for the denial of benefits, payments or reimbursement of  
10 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

11              **c.**       Failing and refusing to provide an adequate notice and/or  
12 explanation for the denial of benefits, payments or reimbursement of  
13 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

14              **d.**       Failing and refusing to provide an explanation for the  
15 denial of benefits, payments or reimbursements of claims of each of  
16 the Patients, and by failing and refusing to set forth the specific reasons  
17 for such denials, all in violation of 29 U.S.C. § 1133(1);

18              **e.**       Failing and refusing to provide an explanation for the  
19 denial of benefits, payments or reimbursements of claims of each of  
20 the Patients, written in a manner calculated to be understood by the  
21 participant, in violation of 29 U.S.C. § 1133(1);

22              **f.**       Failing to afford Plaintiff and/or its Patients with a  
23 reasonable opportunity to engage in an appeals process, in violation of  
24 29 U.S.C. § 1133(2);

25              **g.**       Failing to afford Plaintiff and/or its Patients with a  
26 reasonable opportunity to engage in meaningful appeal process which  
27 was full and fair, in violation of 29 U.S.C. § 1133(2);  
28

1           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
2 with information pertaining to their rights to appeal, including not  
3 limited to those deadlines for filing appeals and/or the requirements  
4 that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

5           **i.**     Violating the minimum requirements for employee benefit  
6 plans pertaining to claims and benefits by participants and  
7 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

8           **j.**     Failing and refusing to establish and maintain reasonable  
9 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

10          **k.**     Establishing, maintaining and enforcing claims  
11 procedures which unduly inhibit the initiation and processing of claims  
12 for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

13          **l.**     Precluding and prohibiting Plaintiff from acting as an  
14 authorized representative of the Patients in pursuing a benefit claim or  
15 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
16 2560.503-1(b)(4);

17          **m.**     Failing and refusing to design, administer and enforce  
18 their processes, procedures and claims administration to ensure that  
19 their governing plan documents and provisions have been applied  
20 consistently with respect to similarly situated participants, beneficiaries  
21 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

22          **n.**     Failing and refusing to pay benefits for authorized  
23 services rendered by Plaintiff;

24          **o.**     Failing to offer coverage for mental health and SUD  
25 treatment in parity with the medical and surgical benefits afforded by  
26 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
27 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and  
28

1                   **p.**      Failing and refusing to pay Plaintiff for the SUD  
2                    treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

3                    **177.** The failure and refusal of the Humana Defendants to provide  
4 coverage, reimbursement, payment and/or benefits for the SUD and/or mental  
5 health treatment benefits rendered by Morningside to Plaintiff's patients who were  
6 covered by the Humana Defendants and check if the Humana Defendants and the  
7 Humana Defendants denial of health insurance benefits coverage constitutes a  
8 breach of the insurance plans and/or employee benefit Plans between the Humana  
9 Defendants and the Patients at issue in this lawsuit.

10                  **178.** The Humana Defendants have arbitrarily and capriciously breached  
11 the obligations set forth in the ERISA Plans issued by the Humana Defendants and  
12 the Humana Defendants have arbitrarily and capriciously breached their  
13 obligations under the ERISA Plans to provide Plaintiff and that as a direct and  
14 proximate result of their actions, Plaintiff has been damaged in an amount equal to  
15 the amount of benefits Plaintiff should have received and to which the Patients  
16 would have been entitled had the Humana Defendants paid the proper amounts,  
17 which Plaintiff estimates to be \$362,679.51.

18                  **179.** As a direct and proximate result of the aforesaid conduct of BCBS Ok  
19 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
20 to suffer in the future, damages, plus interest and other economic and  
21 consequential damages, for a total amount Plaintiff estimates to be \$362,679.51, or  
22 as otherwise determined at the time of trial.

23                  **180.** Plaintiff is entitled to an award of statutory penalties in the amount to  
24 be determined at the time of trial against the Humana Defendants.

25                  **181.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
26 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the Humana  
27 Defendants, Plaintiff has retained the services of legal counsel and has necessarily  
28 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff

1 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
2 action.

3 **SEVENTH CLAIM FOR RELIEF**

4 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

5 **Against BCBS Ala)**

6 **182.** Plaintiff realleges and incorporates by reference each and every  
7 paragraph of this Complaint as though set forth herein.

8 **183.** This claim is alleged by Plaintiff for relief in connection with claims  
9 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
10 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
11 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
12 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
13 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
14 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

15 **184.** Plaintiff is informed and believes, and based thereon alleges, that  
16 BCBS Ala is the insurer, sponsor, and/or financially responsible payer, serve as a  
17 designated plan administrator, and/or services as the named plan administrator's  
18 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
19 with respect to each of the ERISA Plans at issue in this case that are self-insured  
20 plans, but which do not specifically designate a plan administrator, BCBS Ala  
21 effectively controls the decision whether to honor or deny the a claim under the  
22 Plan, exercise authority over the resolution of benefits claims, and/or have  
23 responsibility to pay the claims. BCBS Ala also plays the role as the *de facto* plan  
24 administrator for such ERISA Plans.

25 **185.** With respect to the ERISA Plans provided by BCBS Ala, Plaintiff's  
26 claims against BCBS Ala include 6 separate patients of Morningside. To date,  
27 there remains a balance due and owing by BCBS Ala to Plaintiff in the amount of  
28 \$487,311.36.

1       **186.** The individual patient claims relating to BCBS Ala include the  
2 following:

3               **a.** Patient KB, with a balance due and owing to Plaintiff in the  
4 amount of \$208,156.43. This patient had a Regions Financial Corporation  
5 Advantage Plan through BCBS Ala (the “**KB BCBS Ala Plan**”). The KB  
6 BCBS Ala Plan states: “Benefit levels for most mental health disorders and  
7 substance abuse are not separately stated.” The KB BCBS Ala Plan further  
8 provides that payment for the Morningside Services shall be 90% for  
9 network provider services and 70% for out-of-network provider services of  
10 “allowed amount” for services relating to “[t]he uncontrollable or excessive  
11 abuse of addictive substances, such as (but not limited to) alcohol, drugs, or  
12 other chemicals and the resultant physiological and/or psychological  
13 dependency that develops with continued use.”

14               **b.** Patient CP, with a balance due and owing to Plaintiff in the  
15 amount of \$174,055.84. This patient had an ADS, LLC plan through BCBS  
16 Ala (the “**CP BCBS Ala Plan**”). The CP BCBS Ala Plan states: “Benefit  
17 levels for most mental health disorders and substance abuse are not  
18 separately stated.” The CP BCBS Ala Plan further provides that payment  
19 for the Morningside Services shall be 100% of the “allowed amount” for  
20 services relating to “[t]he uncontrollable or excessive abuse of addictive  
21 substances, such as (but not limited to) alcohol, drugs, or other chemicals  
22 and the resultant physiological and/or psychological dependency that  
23 develops with continued use.”

24               **c.** Patient JD, with a balance due and owing to Plaintiff in the  
25 amount of \$6,000. This patient had a ZF North America, Inc. plan through  
26 BCBS Ala (the “**JD BCBS Ala Plan**”). The JD BCBS Ala Plan states:  
27 “Benefit levels for most mental health disorders and substance abuse are not  
28 separately stated.” The JD BCBS Ala Plan further provides that payment for



1 the Morningside Services shall be shall be 80% for network provider  
2 services and 60% for out-of-network provider services of “allowed amount”  
3 for services relating to “[t]he uncontrollable or excessive abuse of addictive  
4 substances, such as (but not limited to) alcohol, drugs, or other chemicals  
5 and the resultant physiological and/or psychological dependency that  
6 develops with continued use.”

7         **d.** Patient HK, with a balance due and owing to Plaintiff in the  
8 amount of \$71,674.88. This patient had a Blue Secure Silver for Business  
9 plan through BCBS Ala (the “**HK BCBS Ala Plan**”). The HK BCBS Ala  
10 Plan provides that payment for the Morningside Services shall be shall be  
11 100% for network provider services and 50% for out-of-network provider  
12 services of “allowed amount” for services relating to “[t]he uncontrollable or  
13 excessive abuse of addictive substances, such as (but not limited to) alcohol,  
14 drugs, or other chemicals and the resultant physiological and/or  
15 psychological dependency that develops with continued use.

16         **e.** Patient MG, with a balance due and owing to Plaintiff in the  
17 amount of \$19,353.31. This patient had a AAA Cooper Transportation  
18 Consumer Driven Health Plan through BCBS Ala (the “**MG BCBS Ala**  
19 **Plan**”). The MG BCBS Ala Plan covers substance abuse services, and  
20 further provides that payment for the Morningside Services shall be shall be  
21 80% for network provider services and 50% for out-of-network provider  
22 services of “allowed amount” for services relating to “[t]he uncontrollable or  
23 excessive abuse of addictive substances, such as (but not limited to) alcohol,  
24 drugs, or other chemicals and the resultant physiological and/or  
25 psychological dependency that develops with continued use.”

26         **f.** Patient EM, with a balance due and owing to Plaintiff in the  
27 amount of \$8,070.90. This patient had a General Electric Health Plan  
28 through BCBS Ala (the “**MG BCBS Ala Plan**”). The EM BCBS Ala Plan

1 covers behavioral health and substance abuse services at a level in excess of  
2 the 60% minimum required under the Affordable Care Act.”

3 **187.** Plaintiff is informed and believes, and based thereon alleges, that for  
4 each of these claims and for each of the involved Patients, BCBS Ala has failed  
5 and refused to pay, process or adjust these claims in an appropriate fashion by,  
6 among other acts and omissions:

7 **a.** Delaying the processing, adjustment and/or payment of  
8 claims for periods of time greater than 45 days after submission of the  
9 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

10 **b.** Failing and refusing to provide any notice and/or  
11 explanation for the denial of benefits, payments or reimbursement of  
12 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

13 **c.** Failing and refusing to provide an adequate notice and/or  
14 explanation for the denial of benefits, payments or reimbursement of  
15 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

16 **d.** Failing and refusing to provide an explanation for the  
17 denial of benefits, payments or reimbursements of claims of each of  
18 the Patients, and by failing and refusing to set forth the specific reasons  
19 for such denials, all in violation of 29 U.S.C. § 1133(1);

20 **e.** Failing and refusing to provide an explanation for the  
21 denial of benefits, payments or reimbursements of claims of each of  
22 the Patients, written in a manner calculated to be understood by the  
23 participant, in violation of 29 U.S.C. § 1133(1);

24 **f.** Failing to afford Plaintiff and/or its Patients with a  
25 reasonable opportunity to engage in an appeals process, in violation of  
26 29 U.S.C. § 1133(2);

1           **g.**     Failing to afford Plaintiff and/or its Patients with a  
2     reasonable opportunity to engage in meaningful appeal process which  
3     was full and fair, in violation of 29 U.S.C. § 1133(2);

4           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
5     with information pertaining to their rights to appeal, including not  
6     limited to those deadlines for filing appeals and/or the requirements  
7     that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

8           **i.**     Violating the minimum requirements for employee benefit  
9     plans pertaining to claims and benefits by participants and  
10    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

11          **j.**     Failing and refusing to establish and maintain reasonable  
12    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

13          **k.**     Establishing, maintaining and enforcing claims  
14    procedures which unduly inhibit the initiation and processing of claims  
15    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

16          **l.**     Precluding and prohibiting Plaintiff from acting as an  
17    authorized representative of the Patients in pursuing a benefit claim or  
18    appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
19    2560.503-1(b)(4);

20          **m.**     Failing and refusing to design, administer and enforce  
21    their processes, procedures and claims administration to ensure that  
22    their governing plan documents and provisions have been applied  
23    consistently with respect to similarly situated participants, beneficiaries  
24    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

25          **n.**     Failing and refusing to pay benefits for authorized  
26    services rendered by Plaintiff;

27          **o.**     Failing to offer coverage for mental health and SUD  
28    treatment in parity with the medical and surgical benefits afforded by

1 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
2 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

3 **p.** Failing and refusing to pay Plaintiff for the SUD  
4 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

5 **188.** The failure and refusal of BCBS Ala to provide coverage,  
6 reimbursement, payment and/or benefits for the SUD and/or mental health  
7 treatment benefits rendered by Morningside to Plaintiff's patients who were  
8 covered by BCBS Ala and BCBS Ala's denial of health insurance benefits  
9 coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
10 between BCBS Ala and the Patients at issue in this lawsuit.

11 **189.** BCBS Ala has arbitrarily and capriciously breached the obligations  
12 set forth in the ERISA Plans issued by BCBS Ala and BCBS Ala has arbitrarily  
13 and capriciously breached their obligations under the ERISA Plans to provide  
14 Plaintiff and that as a direct and proximate result of the actions by Defendants,  
15 Plaintiff has been damaged in an amount equal to the amount of benefits Plaintiff  
16 should have received and to which the Patients would have been entitled had  
17 BCBS Ala paid the proper amounts, which Plaintiff estimates to be \$487,311.36

18 **190.** As a direct and proximate result of the aforesaid conduct of BCBS Ala  
19 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
20 to suffer in the future, damages, plus interest and other economic and  
21 consequential damages, for a total amount Plaintiff estimates to be \$487,311.36, or  
22 as otherwise determined at the time of trial.

23 **191.** Plaintiff is entitled to an award of statutory penalties in the amount to  
24 be determined at the time of trial against BCBS Ala.

25 **192.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
26 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the BCBS Ala,  
27 Plaintiff has retained the services of legal counsel and has necessarily incurred  
28 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff

1 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
2 action.

3 **EIGHTH CLAIM FOR RELIEF**

4 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

5 **Against the BCBS Tenn)**

6 **193.** Plaintiff realleges and incorporates by reference each and every  
7 paragraph of this Complaint as though set forth herein.

8 **194.** This claim is alleged by Plaintiff for relief in connection with claims  
9 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
10 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
11 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
12 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
13 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
14 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

15 **195.** Plaintiff is informed and believes, and based thereon alleges, that  
16 BCBS Ala is the insurer, sponsor, and/or financially responsible payer, serve as a  
17 designated plan administrator, and/or services as the named plan administrator's  
18 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
19 with respect to each of the ERISA Plans at issue in this case that are self-insured  
20 plans, but which do not specifically designate a plan administrator, BCBS Tenn  
21 effectively controls the decision whether to honor or deny the a claim under the  
22 Plan, exercise authority over the resolution of benefits claims, and/or have  
23 responsibility to pay the claims. BCBS Tenn also plays the role as the *de facto*  
24 plan administrator for such ERISA Plans.

25 **196.** With respect to the ERISA Plans relating to the BCBS Tenn  
26 Defendants, Plaintiff's claims against BCBS Tenn include 18 separate patients of  
27 Morningside. To date, there remains a balance due and owing by BCBS Tenn  
28 Defendants to Plaintiff in the amount of \$1,724,523.68.

1       **197.** The individual patient claims relating to BCBS Tenn include the  
2 following:

3               **a.** Patient MB, with a balance due and owing to Plaintiff in the  
4 amount of \$209,445.02. This patient had a Dollar General Health Plan with  
5 the BCBS Tenn Network (the “**MB BCBS Tenn Plan**”). As required under  
6 the ACA and ERISA, the MB BCBS Tenn Plan must provide plan benefits  
7 for SUD and/or mental health treatment at no less than the amount required  
8 by law of UCR, notwithstanding patient copay and deductible obligations as  
9 set forth in the plan documents.

10              **b.** Patient ZB, with a balance due and owing to Plaintiff in the  
11 amount of \$132,134.39. This patient had an Evolve Financial Group HDHP  
12 plan with the BCBS Tenn Network (the “**ZB BCBS Tenn Plan**”). As  
13 required under the ACA and ERISA, the ZB BCBS Tenn Plan must provide  
14 plan benefits for SUD and/or mental health treatment at no less than the  
15 amount required by law of UCR, notwithstanding patient copay and  
16 deductible obligations as set forth in the plan documents.

17              **c.** Patient KF, with a balance due and owing to Plaintiff in the  
18 amount of \$264.60. This patient had an Ed’s Supply Co. PPO plan with the  
19 BCBS Tenn Network (the “**KF BCBS Tenn Plan**”). As required under the  
20 ACA and ERISA, the KF BCBS Tenn Plan must provide plan benefits for  
21 SUD and/or mental health treatment at no less than the amount required by  
22 law of UCR, notwithstanding patient copay and deductible obligations as set  
23 forth in the plan documents.

24              **d.** Patient CG, with a balance due and owing to Plaintiff in the  
25 amount of \$8,927.60. This patient had a Bridgestone Americas Holdings,  
26 Inc. Health Benefit plan with the BCBS Tenn Network (the “**CG BCBS**  
27 **Tenn Plan**”). As required under the ACA and ERISA, the CG BCBS Tenn  
28 Plan must provide plan benefits for SUD and/or mental health treatment at

1 no less than the amount required by law of UCR, notwithstanding patient  
2 copay and deductible obligations as set forth in the plan documents.

3 e. Patient NH, with a balance due and owing to Plaintiff in the  
4 amount of \$45,761.06. This patient had a Personal Health Coverage PPO  
5 plan with the BCBS Tenn Network (the “**NH BCBS Tenn Plan**”). As  
6 required under the ACA and ERISA, the NH BCBS Tenn Plan must provide  
7 plan benefits for SUD and/or mental health treatment at no less than the  
8 amount required by law of UCR, notwithstanding patient copay and  
9 deductible obligations as set forth in the plan documents.

10 f. Patient KH, with a balance due and owing to Plaintiff in the  
11 amount of \$6,371.10. This patient had a Personal Health Coverage PPO  
12 plan with the BCBS Tenn Network (the “**KH BCBS Tenn Plan**”). As  
13 required under the ACA and ERISA, the KH BCBS Tenn Plan must provide  
14 plan benefits for SUD and/or mental health treatment at no less than the  
15 amount required by law of UCR, notwithstanding patient copay and  
16 deductible obligations as set forth in the plan documents.

17 g. Patient AM, with a balance due and owing to Plaintiff in the  
18 amount of \$45,472.56. This patient had a Local Education PPO plan with  
19 the BCBS Tenn Network (the “**AM BCBS Tenn Plan**”). As required under  
20 the ACA and ERISA, the AM BCBS Tenn Plan must provide plan benefits  
21 for SUD and/or mental health treatment at no less than the amount required  
22 by law of UCR, notwithstanding patient copay and deductible obligations as  
23 set forth in the plan documents.

24 h. Patient KMc, with a balance due and owing to Plaintiff in the  
25 amount of \$131,258.28. This patient had a Charles Tombras Advertising,  
26 Inc. PPO plan with the BCBS Tenn Network (the “**KMc BCBS Tenn**  
27 **Plan**”). As required under the ACA and ERISA, the KMc BCBS Tenn Plan  
28 must provide plan benefits for SUD and/or mental health treatment at no less



1 than the amount required by law of UCR, notwithstanding patient copay and  
2 deductible obligations as set forth in the plan documents.

3 i. Patient MP1, with a balance due and owing to Plaintiff in the  
4 amount of \$3,505.95. This patient had a Logical Systems, LLC PPO plan  
5 with the BCBS Tenn Network (the “**MP1 BCBS Tenn Plan**”). As required  
6 under the ACA and ERISA, the MP1 BCBS Tenn Plan must provide plan  
7 benefits for SUD and/or mental health treatment at no less than the amount  
8 required by law of UCR, notwithstanding patient copay and deductible  
9 obligations as set forth in the plan documents.

10 j. Patient MP2, with a balance due and owing to Plaintiff in the  
11 amount of \$86,285.93. This patient had a Ragan-Smith-Associates, Inc.  
12 BCBS Tenn plan with the BCBS Tenn Network (the “**MP2 BCBS Tenn**  
13 **Plan**”). As required under the ACA and ERISA, the MP2 BCBS Tenn Plan  
14 must provide plan benefits for SUD and/or mental health treatment at no less  
15 than the amount required by law of UCR, notwithstanding patient copay and  
16 deductible obligations as set forth in the plan documents.

17 k. Patient SR, with a balance due and owing to Plaintiff in the  
18 amount of \$238,934.03. This patient had a First South Bancorp HDHP plan  
19 with the BCBS Tenn Network (the “**SR BCBS Tenn Plan**”). As required  
20 under the ACA and ERISA, the SR BCBS Tenn Plan must provide plan  
21 benefits for SUD and/or mental health treatment at no less than the amount  
22 required by law of UCR, notwithstanding patient copay and deductible  
23 obligations as set forth in the plan documents.

24 l. Patient RR, with a balance due and owing to Plaintiff in the  
25 amount of \$152,230.08. BCBS Tenn has not provided information to  
26 Plaintiff whether or not patient RR falls under an ERISA plan or not, so in  
27 an abundance of caution, Plaintiff lists all claims against BCBS Tenn at this  
28 time.

1           **m.**     Patient RS, with a balance due and owing to Plaintiff in the  
2           amount of \$112,519.31. This patient had a Janus ESOP Holdings Inc. PPO  
3           plan with the BCBS Tenn Network (the “**RS BCBS Tenn Plan**”). As  
4           required under the ACA and ERISA, the RS BCBS Tenn Plan must provide  
5           plan benefits for SUD and/or mental health treatment at no less than the  
6           amount required by law of UCR, notwithstanding patient copay and  
7           deductible obligations as set forth in the plan documents.

8           **n.**     Patient JS, with a balance due and owing to Plaintiff in the  
9           amount of \$361,541.97. This patient had a McKee Foods Corporation  
10          CDHP plan with the BCBS Tenn Network (the “**JS BCBS Tenn Plan**”). As  
11          required under the ACA and ERISA, the JS BCBS Tenn Plan must provide  
12          plan benefits for SUD and/or mental health treatment at no less than the  
13          amount required by law of UCR, notwithstanding patient copay and  
14          deductible obligations as set forth in the plan documents.

15          **o.**     Patient MS, with a balance due and owing in the amount of  
16          \$69,661.44. BCBS Tenn has not provided information to Plaintiff whether  
17          or not patient MS falls under an ERISA plan or not, so in an abundance of  
18          caution, Plaintiff lists all claims against BCBS Tenn at this time.

19          **p.**     Patient JT, with a balance due and owing in the amount of  
20          \$65,779.04. This patient had a Envision Healthcare Corporation -- Network  
21          P PPO plan with the BCBS Tenn Network (the “**JT BCBS Tenn Plan**”). As  
22          required under the ACA and ERISA, the JT BCBS Tenn Plan must provide  
23          plan benefits for SUD and/or mental health treatment at no less than the  
24          amount required by law of UCR, notwithstanding patient copay and  
25          deductible obligations as set forth in the plan documents.

26          **q.**     Patient ST, with a balance due and owing in the amount of  
27          \$53,533.24. This patient had a Pyramid Electric, Inc. PPO plan with the  
28          BCBS Tenn Network (the “**ST BCBS Tenn Plan**”). As required under the

1 ACA and ERISA, the ST BCBS Tenn Plan must provide plan benefits for  
2 SUD and/or mental health treatment at no less than the amount required by  
3 law of UCR, notwithstanding patient copay and deductible obligations as set  
4 forth in the plan documents.

5 r. Patient DY, with a balance due and owing in the amount of  
6 \$898.08. This patient had an Anderson County Government — Network P  
7 Health Benefit plan with the BCBS Tenn Network (the “**DY BCBS Tenn**  
8 **Plan**”). As required under the ACA and ERISA, the DY BCBS Tenn Plan  
9 must provide plan benefits for SUD and/or mental health treatment at no less  
10 than the amount required by law of UCR, notwithstanding patient copay and  
11 deductible obligations as set forth in the plan documents.

12 s. The MB BCBS Tenn Plan, the ZB BCBS Tenn Plan, the KF  
13 BCBS Tenn Plan, the CG BCBS Tenn Plan, the NH BCBS Tenn Plan, the  
14 KH BCBS Tenn Plan, the AM BCBS Tenn Plan, the KMc BCBS Tenn Plan,  
15 the MP1 BCBS Tenn Plan, the MP2 BCBS Tenn Plan, the SR BCBS Tenn  
16 Plan, the RR BCBS Tenn Plan, the RS BCBS Tenn Plan, the JS BCBS Tenn  
17 Plan, the MS BCBS Tenn Plan, the JT BCBS Tenn Plan, the ST BCBS Tenn  
18 Plan, and the DY BCBS Tenn Plan shall sometimes be referred to  
19 collectively as the “**BCBS Tenn Plans**”.

20 **198.** Plaintiff is informed and believes, and based thereon alleges, that for  
21 each of these claims and for each of the involved Patients, BCBS Tenn has failed  
22 and refused to pay, process or adjust these claims in an appropriate fashion by,  
23 among other acts and omissions:

24 a. Delaying the processing, adjustment and/or payment of  
25 claims for periods of time greater than 45 days after submission of the  
26 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);  
27  
28

1           **b.**     Failing and refusing to provide any notice and/or  
2           explanation for the denial of benefits, payments or reimbursement of  
3           the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

4           **c.**     Failing and refusing to provide an adequate notice and/or  
5           explanation for the denial of benefits, payments or reimbursement of  
6           claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

7           **d.**     Failing and refusing to provide an explanation for the  
8           denial of benefits, payments or reimbursements of claims of each of  
9           the Patients, and by failing and refusing to set forth the specific reasons  
10          for such denials, all in violation of 29 U.S.C. § 1133(1);

11          **e.**     Failing and refusing to provide an explanation for the  
12          denial of benefits, payments or reimbursements of claims of each of  
13          the Patients, written in a manner calculated to be understood by the  
14          participant, in violation of 29 U.S.C. § 1133(1);

15          **f.**     Failing to afford Plaintiff and/or its Patients with a  
16          reasonable opportunity to engage in an appeals process, in violation of  
17          29 U.S.C. § 1133(2);

18          **g.**     Failing to afford Plaintiff and/or its Patients with a  
19          reasonable opportunity to engage in meaningful appeal process which  
20          was full and fair, in violation of 29 U.S.C. § 1133(2);

21          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
22          with information pertaining to their rights to appeal, including not  
23          limited to those deadlines for filing appeals and/or the requirements  
24          that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

25          **i.**     Violating the minimum requirements for employee benefit  
26          plans pertaining to claims and benefits by participants and  
27          beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;  
28

1           **j.**     Failing and refusing to establish and maintain reasonable  
2     claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

3           **k.**     Establishing, maintaining and enforcing claims  
4     procedures which unduly inhibit the initiation and processing of claims  
5     for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

6           **l.**     Precluding and prohibiting Plaintiff from acting as an  
7     authorized representative of the Patients in pursuing a benefit claim or  
8     appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
9     2560.503-1(b)(4);

10          **m.**    Failing and refusing to design, administer and enforce  
11    their processes, procedures and claims administration to ensure that  
12    their governing plan documents and provisions have been applied  
13    consistently with respect to similarly situated participants, beneficiaries  
14    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

15          **n.**    Failing and refusing to pay benefits for authorized  
16    services rendered by Plaintiff;

17          **o.**    Failing to offer coverage for mental health and SUD  
18    treatment in parity with the medical and surgical benefits afforded by  
19    the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
20    mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

21          **p.**    Failing and refusing to pay Plaintiff for the SUD  
22    treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

23       **199.**    The failure and refusal of BCBS Tenn to provide coverage,  
24    reimbursement, payment and/or benefits for the SUD and/or mental health  
25    treatment benefits rendered by Morningside to Plaintiff's patients who were  
26    covered by BCBS Tenn and BCBS Tenn's denial of health insurance benefits  
27    coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
28    between BCBS Tenn and the Patients at issue in this lawsuit.

1           **200.** BCBS Tenn has arbitrarily and capriciously breached the obligations  
2 set forth in the ERISA Plans issued by BCBS Tenn and BCBS Tenn has arbitrarily  
3 and capriciously breached their obligations under the ERISA Plans to provide  
4 Plaintiff and that as a direct and proximate result of the actions by Defendants,  
5 Plaintiff has been damaged in an amount equal to the amount of benefits Plaintiff  
6 should have received and to which the Patients would have been entitled had  
7 BCBS Tenn paid the proper amounts, which Plaintiff estimates to be  
8 \$1,724,523.68.

9           **201.** As a direct and proximate result of the aforesaid conduct of BCBS  
10 Tenn in failing to provide coverage as required, Plaintiff has suffered, and will  
11 continue to suffer in the future, damages, plus interest and other economic and  
12 consequential damages, for a total amount Plaintiff estimates to be \$1,724,523.68,  
13 or as otherwise determined at the time of trial.

14           **202.** Plaintiff is entitled to an award of statutory penalties in the amount to  
15 be determined at the time of trial against BCBS Tenn.

16           **203.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
17 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the BCBS  
18 Tenn, Plaintiff has retained the services of legal counsel and has necessarily  
19 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
20 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
21 action

22                                   **NINTH CLAIM FOR RELIEF**

23                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

24                                   **Against ComPsych)**

25           **204.** Plaintiff realleges and incorporates by reference each and every  
26 paragraph of this Complaint as though set forth herein.

27           **205.** This claim is alleged by Plaintiff for relief in connection with claims  
28 for treatment rendered to members of an ERISA Plan. This claim seeks to recover

1 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
2 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
3 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
4 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
5 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

6 **206.** Plaintiff is informed and believes, and based thereon alleges, that  
7 ComPsych is the insurer, sponsor, and/or financially responsible payer, serve as a  
8 designated plan administrator, and/or services as the named plan administrator's  
9 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
10 with respect to each of the ERISA Plans at issue in this case that are self-insured  
11 plans, but which do not specifically designate a plan administrator, ComPsych  
12 effectively controls the decision whether to honor or deny the a claim under the  
13 Plan, exercise authority over the resolution of benefits claims, and/or have  
14 responsibility to pay the claims. ComPsych also plays the role as the *de facto* plan  
15 administrator for such ERISA Plans.

16 **207.** With respect to the ERISA Plans relating to ComPsych, Plaintiff's  
17 claims against ComPsych include 6 separate patients of Morningside. To date,  
18 there remains a balance due and owing by ComPsych to Plaintiff in the amount of  
19 \$384,769.03.

20 **208.** ComPsych has not provided information to Plaintiff whether or not  
21 the 6 patients at issue fall under an ERISA plan or not, so in an abundance of  
22 caution, Plaintiff lists all claims against ComPsych at this time. Plaintiff's  
23 individual patient claims relating to ComPsych include the following:

24 **a.** Patient SC, with a balance due and owing to Plaintiff in the  
25 amount of \$99,952.00.

26 **b.** Patient DG, with a balance due and owing to Plaintiff in the  
27 amount of \$84,438.00.  
28



1 c. Patient CB, with a balance due and owing to Plaintiff in the  
2 amount of \$25,699.64.

3 d. Patient NG, with a balance due and owing to Plaintiff in the  
4 amount of \$41,817.50.

5 e. Patient ZR, with a balance due and owing to Plaintiff in the  
6 amount of \$14,294.00.

7 f. Patient BT, with a balance due and owing to Plaintiff in the  
8 amount of \$118,567.89.

9 **209.** Although ComPsych provided certain page excerpts from 4 different  
10 Summary Plan Descriptions (“**SPD’s**”), Plaintiff has no information to identify  
11 which of the SPD’s relate to the ComPsych Patients. Therefore, Plaintiff shall only  
12 set forth the names of the SPD’s as follows:

13 a. DuPont Connection Medical plan (the “**DUPONT**  
14 **COMPSYCH Plan**”). As required under the ACA and ERISA, the  
15 DUPONT COMPSYCH Plan must provide plan benefits for SUD and/or  
16 mental health treatment at no less than the amount required by law of UCR,  
17 notwithstanding patient copay and deductible obligations as set forth in the  
18 plan documents.

19 b. 2015 Edward D. Jones, & Co., L.P., Edward Jones Trust  
20 Company and the Jones Financial Companies, L.L.L.P. plan (the “**2015**  
21 **EDWARD JONES COMPSYCH Plan**”). As required under the ACA and  
22 ERISA, the EDWARD JONES Plan must provide plan benefits for SUD  
23 and/or mental health treatment at no less than the amount required by law of  
24 UCR, notwithstanding patient copay and deductible obligations as set forth  
25 in the plan documents.

26 c. 2018 Edward D. Jones, & Co., L.P., Edward Jones Trust  
27 Company and the Jones Financial Companies, L.L.L.P. plan (the “**2018**  
28 **EDWARD JONES COMPSYCH Plan**”). As required under the ACA and

1 ERISA, the EDWARD COMPSYCHJONES Plan must provide plan  
2 benefits for SUD and/or mental health treatment at no less than the amount  
3 required by law of UCR, notwithstanding patient copay and deductible  
4 obligations as set forth in the plan documents.

5 d. Chicago Regional Council of Carpenters Welfare Fund plan  
6 (the “**CHICAGO COMPSYCH Plan**”). As required under the ACA and  
7 ERISA, the CHICAGO COMPSYCH Plan must provide plan benefits for  
8 SUD and/or mental health treatment at no less than the amount required by  
9 law of UCR, notwithstanding patient copay and deductible obligations as set  
10 forth in the plan documents.

11 e. The DUPONT COMPSYCH Plan, the 2015 EDWARD JONES  
12 COMPSYCH Plan, the 2018 EDWARD JONES COMPSYCH Plan, and the  
13 CHICAGO COMPSYCH Plan, shall sometimes be referred collectively to  
14 as “**the COMPSYCH Plans**”.

15 **210.** Plaintiff is informed and believes, and based thereon alleges, that for  
16 each of these claims and for each of the involved Patients, ComPsych has failed  
17 and refused to pay, process or adjust these claims in an appropriate fashion by,  
18 among other acts and omissions:

19 a. Delaying the processing, adjustment and/or payment of  
20 claims for periods of time greater than 45 days after submission of the  
21 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

22 b. Failing and refusing to provide any notice and/or  
23 explanation for the denial of benefits, payments or reimbursement of  
24 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

25 c. Failing and refusing to provide an adequate notice and/or  
26 explanation for the denial of benefits, payments or reimbursement of  
27 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);  
28

1           **d.**     Failing and refusing to provide an explanation for the  
2     denial of benefits, payments or reimbursements of claims of each of  
3     the Patients, and by failing and refusing to set forth the specific reasons  
4     for such denials, all in violation of 29 U.S.C. § 1133(1);

5           **e.**     Failing and refusing to provide an explanation for the  
6     denial of benefits, payments or reimbursements of claims of each of  
7     the Patients, written in a manner calculated to be understood by the  
8     participant, in violation of 29 U.S.C. § 1133(1);

9           **f.**     Failing to afford Plaintiff and/or its Patients with a  
10    reasonable opportunity to engage in an appeals process, in violation of  
11    29 U.S.C. § 1133(2);

12          **g.**     Failing to afford Plaintiff and/or its Patients with a  
13    reasonable opportunity to engage in meaningful appeal process which  
14    was full and fair, in violation of 29 U.S.C. § 1133(2);

15          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
16    with information pertaining to their rights to appeal, including not  
17    limited to those deadlines for filing appeals and/or the requirements  
18    that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

19          **i.**     Violating the minimum requirements for employee benefit  
20    plans pertaining to claims and benefits by participants and  
21    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

22          **j.**     Failing and refusing to establish and maintain reasonable  
23    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

24          **k.**     Establishing, maintaining and enforcing claims  
25    procedures which unduly inhibit the initiation and processing of claims  
26    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

27          **l.**     Precluding and prohibiting Plaintiff from acting as an  
28    authorized representative of the Patients in pursuing a benefit claim or

1 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
2 2560.503-1(b)(4);

3 **m.** Failing and refusing to design, administer and enforce  
4 their processes, procedures and claims administration to ensure that  
5 their governing plan documents and provisions have been applied  
6 consistently with respect to similarly situated participants, beneficiaries  
7 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

8 **n.** Failing and refusing to pay benefits for authorized  
9 services rendered by Plaintiff;

10 **o.** Failing to offer coverage for mental health and SUD  
11 treatment in parity with the medical and surgical benefits afforded by  
12 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
13 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

14 **p.** Failing and refusing to pay Plaintiff for the SUD  
15 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

16 **211.** The failure and refusal of ComPsych to provide coverage,  
17 reimbursement, payment and/or benefits for the SUD and/or mental health  
18 treatment benefits rendered by Morningside to Plaintiff's patients who were  
19 covered by ComPsych and ComPsych's denial of health insurance benefits  
20 coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
21 between ComPsych and the Patients at issue in this lawsuit.

22 **212.** ComPsych has arbitrarily and capriciously breached the obligations  
23 set forth in the ERISA Plans issued by ComPsych and ComPsych has arbitrarily  
24 and capriciously breached their obligations under the ERISA Plans to provide  
25 Plaintiff and that as a direct and proximate result of the actions by Defendants,  
26 Plaintiff has been damaged in an amount equal to the amount of benefits Plaintiff  
27 should have received and to which the Patients would have been entitled had  
28 ComPsych paid the proper amounts, which Plaintiff estimates to be \$384,769.03.

1           **213.** As a direct and proximate result of the aforesaid conduct of  
2 ComPsych in failing to provide coverage as required, Plaintiff has suffered, and  
3 will continue to suffer in the future, damages, plus interest and other economic and  
4 consequential damages, for a total amount Plaintiff estimates to be \$384,769.03, or  
5 as otherwise determined at the time of trial.

6           **214.** Plaintiff is entitled to an award of statutory penalties in the amount to  
7 be determined at the time of trial against ComPsych.

8           **215.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
9 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the ComPsych,  
10 Plaintiff has retained the services of legal counsel and has necessarily incurred  
11 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
12 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
13 action.

14                                   **TENTH CLAIM FOR RELIEF**

15                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

16                                   **Against Meritain)**

17           **216.** Plaintiff realleges and incorporates by reference each and every  
18 paragraph of this Complaint as though set forth herein.

19           **217.** This claim is alleged by Plaintiff for relief in connection with claims  
20 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
21 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
22 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
23 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
24 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
25 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

26           **218.** Plaintiff is informed and believes, and based thereon alleges, that  
27 Meritain is the insurer, sponsor, and/or financially responsible payer, serve as a  
28 designated plan administrator, and/or services as the named plan administrator's

1 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
2 with respect to each of the ERISA Plans at issue in this case that are self-insured  
3 plans, but which do not specifically designate a plan administrator, Meritain  
4 effectively controls the decision whether to honor or deny the a claim under the  
5 Plan, exercise authority over the resolution of benefits claims, and/or have  
6 responsibility to pay the claims. Meritain also plays the role as the *de facto* plan  
7 administrator for such ERISA Plans.

8       **219.** With respect to the ERISA Plans relating to Meritain, Plaintiff's  
9 claims against Meritain include 7 separate patients of Morningside. To date, there  
10 remains a balance due and owing by Meritain to Plaintiff in the amount of  
11 \$530,622.86. As set forth below, Meritain only produced three plan documents,  
12 although these plans did not have information to connect the ERISA Plans with the  
13 Patients.

14       **220.** The individual patient claims relating to Meritain include the  
15 following:

16           **a.** Patient HA, with a balance due and owing to Plaintiff in the  
17 amount of \$110,259.81. Meritain has not provided information to Plaintiff  
18 whether or not patient HA falls under an ERISA plan or not, so in an  
19 abundance of caution, Plaintiff lists all claims against Meritain at this time.

20           **b.** Patient GB, with a balance due and owing to Plaintiff in the  
21 amount of \$35,915.09. Meritain has not provided information to Plaintiff  
22 whether or not patient GB falls under an ERISA plan or not, so in an  
23 abundance of caution, Plaintiff lists all claims against Meritain at this time.

24           **c.** Patient NH, with a balance due and owing to Plaintiff in the  
25 amount of \$8,358.79. Meritain has not provided information to Plaintiff  
26 whether or not patient NH falls under an ERISA plan or not, so in an  
27 abundance of caution, Plaintiff lists all claims against Meritain at this time.  
28

1           d. Patient AT, with a balance due and owing to Plaintiff in the  
2 amount of \$265,839.78. Meritain has not provided information to Plaintiff  
3 whether or not patient AT falls under an ERISA plan or not, so in an  
4 abundance of caution, Plaintiff lists all claims against Meritain at this time.

5           e. Patient KE, with a balance due and owing to Plaintiff in the  
6 amount of \$43,103.11. Meritain has not provided information to Plaintiff  
7 whether or not patient NH falls under an ERISA plan or not, so in an  
8 abundance of caution, Plaintiff lists all claims against Meritain at this time.

9           f. Patient AL, with a balance due and owing to Plaintiff in the  
10 amount of \$24,234.53. Meritain has not provided information to Plaintiff  
11 whether or not patient AL falls under an ERISA plan or not, so in an  
12 abundance of caution, Plaintiff lists all claims against Meritain at this time.

13           g. Patient AM, with a balance due and owing to Plaintiff in the  
14 amount of \$42,911.75. Meritain has not provided information to Plaintiff  
15 whether or not patient AM falls under an ERISA plan or not, so in an  
16 abundance of caution, Plaintiff lists all claims against Meritain at this time.

17       **221.** Although Meritain provided three ERISA Plan documents (one plan  
18 was produced as twice), Plaintiff has no information to identify which of the  
19 ERISA Plans relate to the Meritain Patients. Therefore, Plaintiff only sets forth the  
20 names of the three ERISA Plans as follows:

21           a. Local 309 Electrical Health and Welfare Fund plan (the  
22 “**LOCAL 309 Meritain Plan**”). As required under the ACA and ERISA,  
23 the LOCAL 309 Meritain Plan must provide plan benefits for SUD and/or  
24 mental health treatment at no less than the amount required by law of UCR,  
25 notwithstanding patient copay and deductible obligations as set forth in the  
26 plan documents.

27           b. iHeart Media, Inc., Group Benefits HDPB plan (the “**IHEART**  
28 **MEDIA Meritain Plan**”). As required under the ACA and ERISA, the



1 IHEART MEDIA Meritain Plan must provide plan benefits for SUD and/or  
2 mental health treatment at no less than the amount required by law of UCR,  
3 notwithstanding patient copay and deductible obligations as set forth in the  
4 plan documents.

5 c. Borrego Community Health Foundation POS 125 Medical Plan  
6 (the “**BORREGO Meritain Plan**”). As required under the ACA and  
7 ERISA, the BORREGO Meritain Plan must provide plan benefits for SUD  
8 and/or mental health treatment at no less than the amount required by law of  
9 UCR, notwithstanding patient copay and deductible obligations as set forth  
10 in the plan documents.

11 d. The LOCAL 309 Meritain Plan, the IHEART MEDIA Meritain  
12 Plan, and the BORREGO Meritain Plan, shall sometimes be referred  
13 collectively to as “**the Meritain Plans**”.

14 **222.** Plaintiff is informed and believes, and based thereon alleges, that for  
15 each of these claims and for each of the involved Patients, Meritain has failed and  
16 refused to pay, process or adjust these claims in an appropriate fashion by, among  
17 other acts and omissions:

18 a. Delaying the processing, adjustment and/or payment of  
19 claims for periods of time greater than 45 days after submission of  
20 the claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

21 b. Failing and refusing to provide any notice and/or  
22 explanation for the denial of benefits, payments or reimbursement of  
23 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

24 c. Failing and refusing to provide an adequate notice and/or  
25 explanation for the denial of benefits, payments or reimbursement of  
26 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

27 d. Failing and refusing to provide an explanation for the  
28 denial of benefits, payments or reimbursements of claims of each of

1 the Patients, and by failing and refusing to set forth the specific reasons  
2 for such denials, all in violation of 29 U.S.C. § 1133(1);

3 e. Failing and refusing to provide an explanation for the  
4 denial of benefits, payments or reimbursements of claims of each of  
5 the Patients, written in a manner calculated to be understood by the  
6 participant, in violation of 29 U.S.C. § 1133(1);

7 f. Failing to afford Plaintiff and/or its Patients with a  
8 reasonable opportunity to engage in an appeals process, in violation of  
9 29 U.S.C. § 1133(2);

10 g. Failing to afford Plaintiff and/or its Patients with a  
11 reasonable opportunity to engage in meaningful appeal process which  
12 was full and fair, in violation of 29 U.S.C. § 1133(2);

13 h. Failing and refusing to provide Plaintiff and/or its Patients  
14 with information pertaining to their rights to appeal, including not  
15 limited to those deadlines for filing appeals and/or the requirements  
16 that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

17 i. Violating the minimum requirements for employee benefit  
18 plans pertaining to claims and benefits by participants and  
19 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

20 j. Failing and refusing to establish and maintain reasonable  
21 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

22 k. Establishing, maintaining and enforcing claims  
23 procedures which unduly inhibit the initiation and processing of claims  
24 for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

25 l. Precluding and prohibiting Plaintiff from acting as an  
26 authorized representative of the Patients in pursuing a benefit claim or  
27 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
28 2560.503-1(b)(4);

1           **m.**     Failing and refusing to design, administer and enforce  
2           their processes, procedures and claims administration to ensure that  
3           their governing plan documents and provisions have been applied  
4           consistently with respect to similarly situated participants, beneficiaries  
5           and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

6           **n.**     Failing and refusing to pay benefits for authorized  
7           services rendered by Plaintiff;

8           **o.**     Failing to offer coverage for mental health and SUD  
9           treatment in parity with the medical and surgical benefits afforded by  
10          the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
11          mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

12          **p.**     Failing and refusing to pay Plaintiff for the SUD  
13          treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

14          **223.**   The failure and refusal of Meritain to provide coverage,  
15          reimbursement, payment and/or benefits for the SUD and/or mental health  
16          treatment benefits rendered by Morningside to Plaintiff's patients who were  
17          covered by Meritain and Meritain's denial of health insurance benefits coverage  
18          constitutes a breach of the insurance plans and/or employee benefit Plans between  
19          Meritain and the Patients at issue in this lawsuit.

20          **224.**   Meritain has arbitrarily and capriciously breached the obligations set  
21          forth in the ERISA Plans issued by Meritain, and Meritain has arbitrarily and  
22          capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
23          and that as a direct and proximate result of the actions by Defendants, Plaintiff has  
24          been damaged in an amount equal to the amount of benefits Plaintiff should have  
25          received and to which the Patients would have been entitled had Meritain paid the  
26          proper amounts, which Plaintiff estimates to be \$530,622.86.

27          **225.**   As a direct and proximate result of the aforesaid conduct of Meritain  
28          in failing to provide coverage as required, Plaintiff has suffered, and will continue

1 to suffer in the future, damages, plus interest and other economic and  
2 consequential damages, for a total amount Plaintiff estimates to be \$530,622.86, or  
3 as otherwise determined at the time of trial.

4       **226.** Plaintiff is entitled to an award of statutory penalties in the amount to  
5 be determined at the time of trial against Meritain.

6       **227.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
7 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the Meritain,  
8 Plaintiff has retained the services of legal counsel and has necessarily incurred  
9 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
10 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
11 action

12                   **ELEVENTH CLAIM FOR RELIEF**

13                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

14                   **Against MHNet)**

15       **228.** Plaintiff realleges and incorporates by reference each and every  
16 paragraph of this Complaint as though set forth herein.

17       **229.** This claim is alleged by Plaintiff for relief in connection with claims  
18 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
19 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
20 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
21 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
22 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
23 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

24       **230.** Plaintiff is informed and believes, and based thereon alleges, that  
25 MHNet is the insurer, sponsor, and/or financially responsible payer, serve as a  
26 designated plan administrator, and/or services as the named plan administrator's  
27 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
28 with respect to each of the ERISA Plans at issue in this case that are self-insured

1 plans, but which do not specifically designate a plan administrator, MHNet  
2 effectively controls the decision whether to honor or deny the a claim under the  
3 ERISA Plan, exercise authority over the resolution of benefits claims, and/or have  
4 responsibility to pay the claims. MHNet also plays the role as the *de facto* plan  
5 administrator for such ERISA Plans.

6 **231.** With respect to the ERISA Plans relating to Defendant MHNet,  
7 Plaintiff's claims against MHNet include 4 separate patients of Morningside. To  
8 date, there remains a balance due and owing by MHNet to Plaintiff in the amount  
9 of \$78,015.96.

10 **232.** MHNet has not provided information to Plaintiff whether or not the  
11 MHNet patients at issue fall under an ERISA plan or not, so in an abundance of  
12 caution, Plaintiff lists all claims against MHNet at this time. Plaintiff's individual  
13 patient claims relating to MHNet include the following:

14 **a.** Patient TB, with a balance due and owing to Plaintiff in the  
15 amount of \$1,707.00.

16 **b.** Patient CH, with a balance due and owing to Plaintiff in the  
17 amount of \$53,833.66.

18 **c.** Patient DR, with a balance due and owing to Plaintiff in the  
19 amount of \$11,229.60.

20 **233.** Plaintiff is informed and believes, and based thereon alleges, that for  
21 each of these claims and for each of the involved Patients, MHNet has failed and  
22 refused to pay, process or adjust these claims in an appropriate fashion by, among  
23 other acts and omissions:

24 **a.** Delaying the processing, adjustment and/or payment of  
25 claims for periods of time greater than 45 days after submission of the  
26 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);  
27  
28

1           **b.**     Failing and refusing to provide any notice and/or  
2           explanation for the denial of benefits, payments or reimbursement of  
3           the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

4           **c.**     Failing and refusing to provide an adequate notice and/or  
5           explanation for the denial of benefits, payments or reimbursement of  
6           claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

7           **d.**     Failing and refusing to provide an explanation for the  
8           denial of benefits, payments or reimbursements of claims of each of  
9           the Patients, and by failing and refusing to set forth the specific reasons  
10          for such denials, all in violation of 29 U.S.C. § 1133(1);

11          **e.**     Failing and refusing to provide an explanation for the  
12          denial of benefits, payments or reimbursements of claims of each of  
13          the Patients, written in a manner calculated to be understood by the  
14          participant, in violation of 29 U.S.C. § 1133(1);

15          **f.**     Failing to afford Plaintiff and/or its Patients with a  
16          reasonable opportunity to engage in an appeals process, in violation of  
17          29 U.S.C. § 1133(2);

18          **g.**     Failing to afford Plaintiff and/or its Patients with a  
19          reasonable opportunity to engage in meaningful appeal process which  
20          was full and fair, in violation of 29 U.S.C. § 1133(2);

21          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
22          with information pertaining to their rights to appeal, including not  
23          limited to those deadlines for filing appeals and/or the requirements  
24          that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

25          **i.**     Violating the minimum requirements for employee benefit  
26          plans pertaining to claims and benefits by participants and  
27          beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;  
28

1           **j.**     Failing and refusing to establish and maintain reasonable  
2     claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

3           **k.**     Establishing, maintaining and enforcing claims  
4     procedures which unduly inhibit the initiation and processing of claims  
5     for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

6           **l.**     Precluding and prohibiting Plaintiff from acting as an  
7     authorized representative of the Patients in pursuing a benefit claim or  
8     appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
9     2560.503-1(b)(4);

10          **m.**    Failing and refusing to design, administer and enforce  
11    their processes, procedures and claims administration to ensure that  
12    their governing plan documents and provisions have been applied  
13    consistently with respect to similarly situated participants, beneficiaries  
14    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

15          **n.**    Failing and refusing to pay benefits for authorized  
16    services rendered by Plaintiff;

17          **o.**    Failing to offer coverage for mental health and SUD  
18    treatment in parity with the medical and surgical benefits afforded by  
19    the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
20    mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

21          **p.**    Failing and refusing to pay Plaintiff for the SUD  
22    treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

23       **234.**    The failure and refusal of MHNet to provide coverage,  
24    reimbursement, payment and/or benefits for the SUD and/or mental health  
25    treatment benefits rendered by Morningside to Plaintiff's patients who were  
26    covered by MHNet and MHNet's denial of health insurance benefits coverage  
27    constitutes a breach of the insurance plans and/or employee benefit Plans between  
28    MHNet and the Patients at issue in this lawsuit.



1       **235.** MHNet has arbitrarily and capriciously breached the obligations set  
2 forth in the ERISA Plans issued by MHNet and MHNet has arbitrarily and  
3 capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
4 and that as a direct and proximate result of the actions by MHNet, Plaintiff has  
5 been damaged in an amount equal to the amount of benefits Plaintiff should have  
6 received and to which the Patients would have been entitled had MHNet paid the  
7 proper amounts, which Plaintiff estimates to be \$78,015.96

8       **236.** As a direct and proximate result of the aforesaid conduct of MHNet in  
9 failing to provide coverage as required, Plaintiff has suffered, and will continue to  
10 suffer in the future, damages, plus interest and other economic and consequential  
11 damages, for a total amount Plaintiff estimates to be \$78,015.96, or as otherwise  
12 determined at the time of trial.

13       **237.** Plaintiff is entitled to an award of statutory penalties in the amount to  
14 be determined at the time of trial against MHNet.

15       **238.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
16 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the MHNet,  
17 Plaintiff has retained the services of legal counsel and has necessarily incurred  
18 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
19 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
20 action.

21                               **TWELFTH CLAIM FOR RELIEF**

22                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

23                               **Against the Providence)**

24       **239.** Plaintiff realleges and incorporates by reference each and every  
25 paragraph of this Complaint as though set forth herein.

26       **240.** This claim is alleged by Plaintiff for relief in connection with claims  
27 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
28 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §

1 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
2 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
3 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
4 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

5 **241.** Plaintiff is informed and believes, and based thereon alleges, that  
6 Providence is the insurer, sponsor, and/or financially responsible payer, serve as a  
7 designated plan administrator, and/or services as the named plan administrator's  
8 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
9 with respect to each of the ERISA Plans at issue in this case that are self-insured  
10 plans, but which do not specifically designate a plan administrator, Providence  
11 effectively controls the decision whether to honor or deny the a claim under the  
12 Plan, exercise authority over the resolution of benefits claims, and/or have  
13 responsibility to pay the claims. Providence also plays the role as the *de facto* plan  
14 administrator for such ERISA Plans.

15 **242.** On May 4, 2020, the District Court held: "[T]he Court has no  
16 difficulty finding that [Providence is] subject to personal jurisdiction in California.  
17 [Providence] contracted to sell insurance policies to California patients, who then  
18 sought treatment and reimbursement at a California facility, and (according to  
19 Plaintiff's allegations) [Providence] authorized that California facility to provide  
20 treatment. Through this course of conduct, the out-of-state Defendants 'reach[ed]  
21 out beyond one state and creat[d] continuing relationships and obligations with  
22 citizens of another state,' rendering them 'subject to regulation and sanctions' in  
23 California. *See Burger King*, 471 U.S. at 473 (citations omitted)." [ECF No. 383,  
24 p. 14]

25 **243.** With respect to the ERISA Plans relating to Providence, Plaintiff's  
26 claims against Providence include 5 separate patients of Morningside. To date,  
27 there remains a balance due and owing by Providence to Plaintiff in the amount of  
28 \$310,964.45.

1       **244.** Providence has not provided information to Plaintiff whether or not  
2 the 5 patients at issue fall under an ERISA plan or not, so in an abundance of  
3 caution, Plaintiff lists all claims against Providence at this time. Plaintiff's  
4 individual patient claims relating to Providence include the following:

5           **a.** Patient WG, with a balance due and owing to Plaintiff in the  
6 amount of \$115,728.73.

7           **b.** Patient TG, with a balance due and owing to Plaintiff in the  
8 amount of \$55,185.00.

9           **c.** Patient AM, with a balance due and owing to Plaintiff in the  
10 amount of \$111,038.87.

11           **d.** Patient BO, with a balance due and owing to Plaintiff in the  
12 amount of \$7,210.00.

13           **e.** Patient ST, with a balance due and owing to Plaintiff in the  
14 amount \$21,805.85.

15       **245.** Although Providence provided page excerpts from three different  
16 health benefit plans with respect to three Providence Patients, Plaintiff does not  
17 have the full plans or information about the remaining two Providence Patients.  
18 Therefore, Plaintiff simply sets forth the names of the plans from the excerpts  
19 provided by Providence as follows:

20           **a.** Patients WG and BO had the 2017 Providence Health &  
21 Services Health and Welfare Benefit Plan (the "**Providence H&S Plan**").  
22 As required under the ACA and ERISA, the Providence H&S Plan must  
23 provide plan benefits for SUD and/or mental health treatment at no less than  
24 the amount required by law of UCR, notwithstanding patient copay and  
25 deductible obligations as set forth in the plan documents.

26           **b.** Patient AM had the Oregon Public Employees Benefit Board  
27 plan (the "**Providence PEBB Plan**"). As required under the ACA and  
28 ERISA, the Providence PEBB Plan must provide plan benefits for SUD

1 and/or mental health treatment at no less than the amount required by law of  
2 UCR, notwithstanding patient copay and deductible obligations as set forth  
3 in the plan documents.

4 c. The Providence H&S Plan and the Providence PEBB Plan shall  
5 sometimes be referred to collectively as the “**Providence Plans**”.

6 **246.** Plaintiff is informed and believes, and based thereon alleges, that for  
7 each of these claims and for each of the involved Patients, Providence has failed  
8 and refused to pay, process or adjust these claims in an appropriate fashion by,  
9 among other acts and omissions:

10 a. Delaying the processing, adjustment and/or payment of  
11 claims for periods of time greater than 45 days after submission of the  
12 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

13 b. Failing and refusing to provide any notice and/or  
14 explanation for the denial of benefits, payments or reimbursement of  
15 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

16 c. Failing and refusing to provide an adequate notice and/or  
17 explanation for the denial of benefits, payments or reimbursement of  
18 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

19 d. Failing and refusing to provide an explanation for the  
20 denial of benefits, payments or reimbursements of claims of each of  
21 the Patients, and by failing and refusing to set forth the specific reasons  
22 for such denials, all in violation of 29 U.S.C. § 1133(1);

23 e. Failing and refusing to provide an explanation for the  
24 denial of benefits, payments or reimbursements of claims of each of  
25 the Patients, written in a manner calculated to be understood by the  
26 participant, in violation of 29 U.S.C. § 1133(1);  
27  
28

1           **f.**     Failing to afford Plaintiff and/or its Patients with a  
2     reasonable opportunity to engage in an appeals process, in violation of  
3     29 U.S.C. § 1133(2);

4           **g.**     Failing to afford Plaintiff and/or its Patients with a  
5     reasonable opportunity to engage in meaningful appeal process which  
6     was full and fair, in violation of 29 U.S.C. § 1133(2);

7           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
8     with information pertaining to their rights to appeal, including not  
9     limited to those deadlines for filing appeals and/or the requirements  
10    that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

11          **i.**     Violating the minimum requirements for employee benefit  
12    plans pertaining to claims and benefits by participants and  
13    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

14          **j.**     Failing and refusing to establish and maintain reasonable  
15    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

16          **k.**     Establishing, maintaining and enforcing claims  
17    procedures which unduly inhibit the initiation and processing of claims  
18    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

19          **l.**     Precluding and prohibiting Plaintiff from acting as an  
20    authorized representative of the Patients in pursuing a benefit claim or  
21    appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
22    2560.503-1(b)(4);

23          **m.**     Failing and refusing to design, administer and enforce  
24    their processes, procedures and claims administration to ensure that  
25    their governing plan documents and provisions have been applied  
26    consistently with respect to similarly situated participants, beneficiaries  
27    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);  
28

1           **n.**     Failing and refusing to pay benefits for authorized  
2           services rendered by Plaintiff;

3           **o.**     Failing to offer coverage for mental health and SUD  
4           treatment in parity with the medical and surgical benefits afforded by  
5           the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
6           mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

7           **p.**     Failing and refusing to pay Plaintiff for the SUD  
8           treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

9           **247.** The failure and refusal of Providence to provide coverage,  
10          reimbursement, payment and/or benefits for the SUD and/or mental health  
11          treatment benefits rendered by Morningside to Plaintiff's patients who were  
12          covered by Providence and Providence's denial of health insurance benefits  
13          coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
14          between Providence and the Patients at issue in this lawsuit.

15          **248.** Providence has arbitrarily and capriciously breached the obligations  
16          set forth in the ERISA Plans issued by Providence and Providence has arbitrarily  
17          and capriciously breached their obligations under the ERISA Plans to provide  
18          Plaintiff and that as a direct and proximate result of the actions by Providence,  
19          Plaintiff has been damaged in an amount equal to the amount of benefits Plaintiff  
20          should have received and to which the Patients would have been entitled had  
21          Providence paid the proper amounts, which Plaintiff estimates to be \$310,964.45.

22          **249.** As a direct and proximate result of the aforesaid conduct of  
23          Providence in failing to provide coverage as required, Plaintiff has suffered, and  
24          will continue to suffer in the future, damages, plus interest and other economic and  
25          consequential damages, for a total amount Plaintiff estimates to be \$310,964.45, or  
26          as otherwise determined at the time of trial.

27          **250.** Plaintiff is entitled to an award of statutory penalties in the amount to  
28          be determined at the time of trial against Providence.

1           **251.** Plaintiff is entitled to an award of reasonable attorneys’ fees pursuant  
2 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the  
3 Providence, Plaintiff has retained the services of legal counsel and has necessarily  
4 incurred attorneys’ fees and costs in prosecuting this action. Furthermore, Plaintiff  
5 anticipates incurring additional attorneys’ fees and costs hereafter pursuing this  
6 action.

7                           **THIRTEENTH CLAIM FOR RELIEF**

8                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

9                           **Against UMR)**

10           **252.** Plaintiff realleges and incorporates by reference each and every  
11 paragraph of this Complaint as though set forth herein.

12           **253.** This claim is alleged by Plaintiff for relief in connection with claims  
13 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
14 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
15 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
16 Patients’ benefits under the ERISA Plans. As the assignee of benefits under the  
17 ERISA Plans, Plaintiff is a “beneficiary” entitled to collect benefits under the terms  
18 of the ERISA Plans, and is the “claimant” for purposes of ERISA.

19           **254.** Plaintiff is informed and believes, and based thereon alleges, that  
20 UMR is the insurer, sponsor, and/or financially responsible payer, serve as a  
21 designated plan administrator, and/or services as the named plan administrator’s  
22 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
23 with respect to each of the ERISA Plans at issue in this case that are self-insured  
24 plans, but which do not specifically designate a plan administrator, UMR  
25 effectively controls the decision whether to honor or deny the a claim under the  
26 Plan, exercise authority over the resolution of benefits claims, and/or have  
27 responsibility to pay the claims. UMR also plays the role as the *de facto* plan  
28 administrator for such ERISA Plans.



1       **255.** With respect to the ERISA Plans relating to UMR, Plaintiff's claims  
2 against UMR Defendants include 11 separate patients of Morningside. To date,  
3 there remains a balance due and owing by UMR to Plaintiff in the amount of  
4 \$1,253,898.13.

5       **256.** The individual patient claims relating to UMR Defendants include the  
6 following:

7           **a.** Patient CS, with a balance due and owing to Plaintiff in the  
8 amount of \$17,026.20. This patient had a UMR plan with Community  
9 Health Care, Inc. (the "**CS UMR Plan**"). As required under the ACA and  
10 ERISA, the CS UMR Plan must provide plan benefits for SUD and/or  
11 mental health treatment at no less than the amount required by law of UCR,  
12 notwithstanding patient copay and deductible obligations as set forth in the  
13 plan documents.

14           **b.** Patient CG, with a balance due and owing to Plaintiff in the  
15 amount of \$201,650.25. This patient had a UMR plan with Abbott  
16 Laboratories (the "**CG UMR Plan**"). As required under the ACA and  
17 ERISA, the CG UMR Plan must provide plan benefits for SUD and/or  
18 mental health treatment at no less than the amount required by law of UCR,  
19 notwithstanding patient copay and deductible obligations as set forth in the  
20 plan documents.

21           **c.** Patient IL, with a balance due and owing to Plaintiff in the  
22 amount of \$170,510.00. This patient had a UMR plan with Trivergent  
23 Health Alliance MSO, LLC Hagerstown, MD (the "**IL UMR Plan**"). As  
24 required under the ACA and ERISA, the IL UMR Plan must provide plan  
25 benefits for SUD and/or mental health treatment at no less than the amount  
26 required by law of UCR, notwithstanding patient copay and deductible  
27 obligations as set forth in the plan documents.  
28

1           d.     Patient CDG, with a balance due and owing to Plaintiff in the  
2           amount of \$90,003.69. This patient had a UMR plan with University of  
3           North Carolina Health Care System Chapel Hill NC (the “**CDG UMR**  
4           **Plan**”). As required under the ACA and ERISA, the CDG UMR Plan must  
5           provide plan benefits for SUD and/or mental health treatment at no less than  
6           the amount required by law of UCR, notwithstanding patient copay and  
7           deductible obligations as set forth in the plan documents.

8           e.     Patient LN, with a balance due and owing to Plaintiff in the  
9           amount of \$3,850.00. This patient had a UMR plan with Bi-Mart  
10          Corporation (the “**LN UMR Plan**”). As required under the ACA and  
11          ERISA, the LN UMR Plan must provide plan benefits for SUD and/or  
12          mental health treatment at no less than the amount required by law of UCR,  
13          notwithstanding patient copay and deductible obligations as set forth in the  
14          plan documents.

15          f.     Patient EA, with a balance due and owing to Plaintiff in the  
16          amount of \$10,930.00. This patient had a UMR plan with Vivant Solar, Inc.  
17          (the “**EA UMR Plan**”). As required under the ACA and ERISA, the EA  
18          UMR Plan must provide plan benefits for SUD and/or mental health  
19          treatment at no less than the amount required by law of UCR,  
20          notwithstanding patient copay and deductible obligations as set forth in the  
21          plan documents.

22          g.     Patient JD, with a balance due and owing to Plaintiff in the  
23          amount of \$24,519.83. This patient had a UMR plan with Caesars  
24          Enterprise Services, LLC Las Vegas NV (the “**JD UMR Plan**”). As  
25          required under the ACA and ERISA, the JD UMR Plan must provide plan  
26          benefits for SUD and/or mental health treatment at no less than the amount  
27          required by law of UCR, notwithstanding patient copay and deductible  
28          obligations as set forth in the plan documents.

1           **h.**     Patient JS, with a balance due and owing to Plaintiff in the  
2           amount of \$8,513.10. This patient had a UMR plan with A Place For Mom,  
3           Inc. (the “**JS UMR Plan**”). As required under the ACA and ERISA, the JS  
4           UMR Plan must provide plan benefits for SUD and/or mental health  
5           treatment at no less than the amount required by law of UCR,  
6           notwithstanding patient copay and deductible obligations as set forth in the  
7           plan documents.

8           **i.**     Patient BT, with a balance due and owing to Plaintiff in the  
9           amount of \$135,942.58. This patient had a UMR plan with Merchant  
10          Services, Inc., d/b/a EVO Merchant Services (the “**BT UMR Plan**”). As  
11          required under the ACA and ERISA, the BT UMR Plan must provide plan  
12          benefits for SUD and/or mental health treatment at no less than the amount  
13          required by law of UCR, notwithstanding patient copay and deductible  
14          obligations as set forth in the plan documents.

15          **j.**     Patient CR, with a balance due and owing to Plaintiff in the  
16          amount of \$243,195.40. This patient had a UMR plan with TRH Health  
17          Insurance Company Home Office (the “**CR UMR Plan**”). As required  
18          under the ACA and ERISA, the CR UMR Plan must provide plan benefits  
19          for SUD and/or mental health treatment at no less than the amount required  
20          by law of UCR, notwithstanding patient copay and deductible obligations as  
21          set forth in the plan documents.

22          **k.**     Patient CM, with a balance due and owing to Plaintiff in the  
23          amount of \$347,757.08. This patient had a UMR plan with the County of  
24          Sheboygan (the “**CM UMR Plan**”). As required under the ACA and  
25          ERISA, the CM UMR Plan must provide plan benefits for SUD and/or  
26          mental health treatment at no less than the amount required by law of UCR,  
27          notwithstanding patient copay and deductible obligations as set forth in the  
28          plan documents.

1           **I.**       The CS UMR Plan, the CG UMR Plan, the IL Plan, the CDG  
2       UMR Plan, the LN UMR Plan, the EA UMR Plan, the JD Plan, the JS UMR  
3       Plan, the BT UMR Plan, the CR UMR Plan, and the CM UMR Plan shall  
4       sometimes be referred to collectively as the “**UMR Plans**”.

5       **257.** Plaintiff is informed and believes, and based thereon alleges, that for  
6       each of these claims and for each of the involved Patients, UMR has failed and  
7       refused to pay, process or adjust these claims in an appropriate fashion by, among  
8       other acts and omissions:

9           **a.**       Delaying the processing, adjustment and/or payment of  
10       claims for periods of time greater than 45 days after submission of the  
11       claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

12          **b.**       Failing and refusing to provide any notice and/or  
13       explanation for the denial of benefits, payments or reimbursement of  
14       the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

15          **c.**       Failing and refusing to provide an adequate notice and/or  
16       explanation for the denial of benefits, payments or reimbursement of  
17       claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

18          **d.**       Failing and refusing to provide an explanation for the  
19       denial of benefits, payments or reimbursements of claims of each of  
20       the Patients, and by failing and refusing to set forth the specific reasons  
21       for such denials, all in violation of 29 U.S.C. § 1133(1);

22          **e.**       Failing and refusing to provide an explanation for the  
23       denial of benefits, payments or reimbursements of claims of each of  
24       the Patients, written in a manner calculated to be understood by the  
25       participant, in violation of 29 U.S.C. § 1133(1);

26          **f.**       Failing to afford Plaintiff and/or its Patients with a  
27       reasonable opportunity to engage in an appeals process, in violation of  
28       29 U.S.C. § 1133(2);

1           **g.**     Failing to afford Plaintiff and/or its Patients with a  
2     reasonable opportunity to engage in meaningful appeal process which  
3     was full and fair, in violation of 29 U.S.C. § 1133(2);

4           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
5     with information pertaining to their rights to appeal, including not  
6     limited to those deadlines for filing appeals and/or the requirements  
7     that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

8           **i.**     Violating the minimum requirements for employee benefit  
9     plans pertaining to claims and benefits by participants and  
10    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

11          **j.**     Failing and refusing to establish and maintain reasonable  
12    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

13          **k.**     Establishing, maintaining and enforcing claims  
14    procedures which unduly inhibit the initiation and processing of claims  
15    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

16          **l.**     Precluding and prohibiting Plaintiff from acting as an  
17    authorized representative of the Patients in pursuing a benefit claim or  
18    appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
19    2560.503-1(b)(4);

20          **m.**     Failing and refusing to design, administer and enforce  
21    their processes, procedures and claims administration to ensure that  
22    their governing plan documents and provisions have been applied  
23    consistently with respect to similarly situated participants, beneficiaries  
24    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

25          **n.**     Failing and refusing to pay benefits for authorized  
26    services rendered by Plaintiff;

27          **o.**     Failing to offer coverage for mental health and SUD  
28    treatment in parity with the medical and surgical benefits afforded by

1 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
2 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

3 p. Failing and refusing to pay Plaintiff for the SUD  
4 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

5 **258.** The failure and refusal of UMR to provide coverage, reimbursement,  
6 payment and/or benefits for the SUD and/or mental health treatment benefits  
7 rendered by Morningside to Plaintiff's patients who were covered by UMR and  
8 UMR's denial of health insurance benefits coverage constitutes a breach of the  
9 insurance plans and/or employee benefit Plans between UMR and the Patients at  
10 issue in this lawsuit.

11 **259.** UMR has arbitrarily and capriciously breached the obligations set  
12 forth in the ERISA Plans issued by UMR and UMR has arbitrarily and capriciously  
13 breached its obligations under the ERISA Plans to provide Plaintiff and that as a  
14 direct and proximate result of the actions by UMR, Plaintiff has been damaged in  
15 an amount equal to the amount of benefits Plaintiff should have received and to  
16 which the Patients would have been entitled had UMR paid the proper amounts,  
17 which Plaintiff estimates to be \$1,253,898.13.

18 **260.** As a direct and proximate result of the aforesaid conduct of UMR in  
19 failing to provide coverage as required, Plaintiff has suffered, and will continue to  
20 suffer in the future, damages, plus interest and other economic and consequential  
21 damages, for a total amount Plaintiff estimates to be \$1,253,898.13, or as otherwise  
22 determined at the time of trial.

23 **261.** Plaintiff is entitled to an award of statutory penalties in the amount to  
24 be determined at the time of trial against UMR.

25 **262.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
26 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the UMR,  
27 Plaintiff has retained the services of legal counsel and has necessarily incurred  
28 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff

1 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
2 action.

3  
4 **FOURTEENTH CLAIM FOR RELIEF**

5 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

6 **Against Sierra)**

7 **263.** Plaintiff realleges and incorporates by reference each and every  
8 paragraph of this Complaint as though set forth herein.

9 **264.** This claim is alleged by Plaintiff for relief in connection with claims  
10 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
11 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
12 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
13 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
14 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
15 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

16 **265.** Plaintiff is informed and believes, and based thereon alleges, that  
17 Sierra is the insurer, sponsor, and/or financially responsible payer, serve as a  
18 designated plan administrator, and/or services as the named plan administrator's  
19 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
20 with respect to each of the ERISA Plans at issue in this case that are self-insured  
21 plans, but which do not specifically designate a plan administrator, Sierra  
22 effectively controls the decision whether to honor or deny the a claim under the  
23 Plan, exercise authority over the resolution of benefits claims, and/or have  
24 responsibility to pay the claims. Sierra also plays the role as the *de facto* plan  
25 administrator for such ERISA Plans.

26 **266.** With respect to the ERISA Plans relating to Sierra, Plaintiff's claims  
27 against Sierra include 1 patient of Morningside. To date, there remains a balance  
28 due and owing by Sierra to Plaintiff in the amount of \$72,693.27.



1           **267.** The individual patient claims relating to Sierra include the following:  
2 Patient PM, with a balance due and owing to Plaintiff in the amount of \$72,693.27.  
3 This patient had a Precision Plumbing Inc. plan (the “**PM Sierra Plan**” or the  
4 “**Sierra Plan**”). As required under the ACA and ERISA, the PM SIERRA Plan  
5 must provide plan benefits for SUD and/or mental health treatment at no less than  
6 the amount required by law of UCR, notwithstanding patient copay and deductible  
7 obligations as set forth in the plan documents.

8           **268.** Plaintiff is informed and believes, and based thereon alleges, that for  
9 each of these claims and for each of the involved Patients, Sierra has failed and  
10 refused to pay, process or adjust these claims in an appropriate fashion by, among  
11 other acts and omissions:

12                   **a.** Delaying the processing, adjustment and/or payment of  
13 claims for periods of time greater than 45 days after submission of  
14 the claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

15                   **b.** Failing and refusing to provide any notice and/or  
16 explanation for the denial of benefits, payments or reimbursement of  
17 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

18                   **c.** Failing and refusing to provide an adequate notice and/or  
19 explanation for the denial of benefits, payments or reimbursement of  
20 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

21                   **d.** Failing and refusing to provide an explanation for the  
22 denial of benefits, payments or reimbursements of claims of each of  
23 the Patients, and by failing and refusing to set forth the specific reasons  
24 for such denials, all in violation of 29 U.S.C. § 1133(1);

25                   **e.** Failing and refusing to provide an explanation for the  
26 denial of benefits, payments or reimbursements of claims of each of  
27 the Patients, written in a manner calculated to be understood by the  
28 participant, in violation of 29 U.S.C. § 1133(1);

1           **f.**     Failing to afford Plaintiff and/or its Patients with a  
2 reasonable opportunity to engage in an appeals process, in violation of  
3 29 U.S.C. § 1133(2);

4           **g.**     Failing to afford Plaintiff and/or its Patients with a  
5 reasonable opportunity to engage in meaningful appeal process which  
6 was full and fair, in violation of 29 U.S.C. § 1133(2);

7           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
8 with information pertaining to their rights to appeal, including not  
9 limited to those deadlines for filing appeals and/or the requirements  
10 that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

11          **i.**     Violating the minimum requirements for employee benefit  
12 plans pertaining to claims and benefits by participants and  
13 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

14          **j.**     Failing and refusing to establish and maintain reasonable  
15 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

16          **k.**     Establishing, maintaining and enforcing claims  
17 procedures which unduly inhibit the initiation and processing of claims  
18 for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

19          **l.**     Precluding and prohibiting Plaintiff from acting as an  
20 authorized representative of the Patients in pursuing a benefit claim or  
21 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
22 2560.503-1(b)(4);

23          **m.**     Failing and refusing to design, administer and enforce  
24 their processes, procedures and claims administration to ensure that  
25 their governing plan documents and provisions have been applied  
26 consistently with respect to similarly situated participants, beneficiaries  
27 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);  
28

1           **n.**     Failing and refusing to pay benefits for authorized  
2     services rendered by Plaintiff;

3           **o.**     Failing to offer coverage for mental health and SUD  
4     treatment in parity with the medical and surgical benefits afforded by  
5     the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
6     mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

7           **p.**     Failing and refusing to pay Plaintiff for the SUD  
8     treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

9       **269.** The failure and refusal of Sierra to provide coverage, reimbursement,  
10   payment and/or benefits for the SUD and/or mental health treatment benefits  
11   rendered by Morningside to Plaintiff's patients who were covered by Sierra and  
12   Sierra's denial of health insurance benefits coverage constitutes a breach of the  
13   insurance plans and/or employee benefit Plans between Sierra and the Patients at  
14   issue in this lawsuit.

15       **270.** Sierra has arbitrarily and capriciously breached the obligations set  
16   forth in the ERISA Plans issued by Sierra and Sierra has arbitrarily and  
17   capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
18   and that as a direct and proximate result of the actions by Defendants, Plaintiff has  
19   been damaged in an amount equal to the amount of benefits Plaintiff should have  
20   received and to which the Patients would have been entitled had Sierra paid the  
21   proper amounts, which Plaintiff estimates to be \$72,693.27.

22       **271.** As a direct and proximate result of the aforesaid conduct of Sierra in  
23   failing to provide coverage as required, Plaintiff has suffered, and will continue to  
24   suffer in the future, damages, plus interest and other economic and consequential  
25   damages, for a total amount Plaintiff estimates to be \$72,693.27, or as otherwise  
26   determined at the time of trial.

27       **272.** Plaintiff is entitled to an award of statutory penalties in the amount to  
28   be determined at the time of trial against Sierra.

1       **273.** Plaintiff is entitled to an award of reasonable attorneys’ fees pursuant  
2 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the Sierra,  
3 Plaintiff has retained the services of legal counsel and has necessarily incurred  
4 attorneys’ fees and costs in prosecuting this action. Furthermore, Plaintiff  
5 anticipates incurring additional attorneys’ fees and costs hereafter pursuing this  
6 action.

7                               **FIFTEENTH CLAIM FOR RELIEF**

8                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

9                               **Against Medical Mutual)**

10       **274.** Plaintiff realleges and incorporates by reference each and every  
11 paragraph of this Complaint as though set forth herein.

12       **275.** This claim is alleged by Plaintiff for relief in connection with claims  
13 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
14 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
15 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
16 Patients’ benefits under the ERISA Plans. As the assignee of benefits under the  
17 ERISA Plans, Plaintiff is a “beneficiary” entitled to collect benefits under the terms  
18 of the ERISA Plans, and is the “claimant” for purposes of ERISA.

19       **276.** Plaintiff is informed and believes, and based thereon alleges, that  
20 Medical Mutual is the insurer, sponsor, and/or financially responsible payer, serve  
21 as a designated plan administrator, and/or services as the named plan  
22 administrator’s designee. Plaintiff is further informed and believes, and based  
23 thereon alleges, that with respect to each of the ERISA Plans at issue in this case  
24 that are self-insured plans, but which do not specifically designate a plan  
25 administrator, Medical Mutual effectively controls the decision whether to honor  
26 or deny the a claim under the Plan, exercise authority over the resolution of  
27 benefits claims, and/or have responsibility to pay the claims. Medical Mutual also  
28 plays the role as the *de facto* plan administrator for such ERISA Plans.

1       **277.** With respect to the ERISA Plans relating to Medical Mutual,  
2 Plaintiff's claims against Medical Mutual include 8 separate patients of  
3 Morningside. To date, there remains a balance due and owing by Medical Mutual  
4 to Plaintiff in the amount of \$1,698,911.64.

5       **278.** The individual patient claims relating to Medical Mutual include the  
6 following:

7               **a.** Patient BD, with a balance due and owing to Plaintiff in the  
8 amount of \$340,266.78.

9               **b.** Patient TD, with a balance due and owing to Plaintiff in the  
10 amount of \$138,001.57.

11              **c.** Patient SG, with a balance due and owing to Plaintiff in the  
12 amount of \$233,506.74.

13              **d.** Patient JG, with a balance due and owing to Plaintiff in the  
14 amount of \$297,572.04.

15              **e.** Patient RL, with a balance due and owing to Plaintiff in the  
16 amount of \$30,785.50.

17              **f.** Patient JM, with a balance due and owing to Plaintiff in the  
18 amount of \$265,551.32.

19              **g.** Patient MR, with a balance due and owing to Plaintiff in the  
20 amount of \$25,713.12.

21              **h.** Patient JS, with a balance due and owing to Plaintiff in the  
22 amount of \$367,514.57.

23       **279.** Although Medical Mutual provided ERISA Plan documents, Plaintiff  
24 has no information to identify which of the ERISA Plans relate to the Medical  
25 Mutual Patients. Therefore, Plaintiff simply sets forth the names of the Plan  
26 Documents as follows:

27              **a.** PPO Network Comprehensive Major Medical Health Care plan  
28 (the "**PPO Network Comprehensive 1 Medical Mutual Plan**"). As

1 required under the ACA and ERISA, the PPO Network Comprehensive 1  
2 Medical Mutual Plan must provide plan benefits for SUD and/or mental  
3 health treatment at no less than the amount required by law of UCR,  
4 notwithstanding patient copay and deductible obligations as set forth in the  
5 plan documents.

6           **b.** PPO Network Comprehensive Major Medical Health Care plan  
7 (the “**PPO Network Comprehensive 2 Medical Mutual Plan**”). As  
8 required under the ACA and ERISA, the PPO Network Comprehensive 2  
9 Medical Mutual Plan must provide plan benefits for SUD and/or mental  
10 health treatment at no less than the amount required by law of UCR,  
11 notwithstanding patient copay and deductible obligations as set forth in the  
12 plan documents.

13           **c.** Ohio Public Employees Retirement System plan (the “**OPERS**  
14 **Medical Mutual Plan**”). As required under the ACA and ERISA, the  
15 OPERS Medical Mutual Plan must provide plan benefits for SUD and/or  
16 mental health treatment at no less than the amount required by law of UCR,  
17 notwithstanding patient copay and deductible obligations as set forth in the  
18 plan documents.

19           **d.** COSE Health and Wellness Trust (“MEWA”) plan (the “**COSE**  
20 **Medical Mutual Plan**”). As required under the ACA and ERISA, the  
21 COSE Medical Mutual Plan must provide plan benefits for SUD and/or  
22 mental health treatment at no less than the amount required by law of UCR,  
23 notwithstanding patient copay and deductible obligations as set forth in the  
24 plan documents.

25           **e.** IP/MM/OFF SILVER CLASSIC 2000/4000 MMRX Health  
26 plan (the “**IP/MM/OFF MEDICAL Mutual Plan**”). As required under the  
27 ACA and ERISA, the IP/MM/OFF Medical Mutual Plan must provide plan  
28 benefits for SUD and/or mental health treatment at no less than the amount

1 required by law of UCR, notwithstanding patient copay and deductible  
2 obligations as set forth in the plan documents.

3 f. SMALL GROUP CONSUMER SUITE, SM PLUS HAS  
4 3000/6000 P-PLAN, MM RX plan (the “**SMALL GROUP Medical**  
5 **Mutual Plan**”). As required under the ACA and ERISA, the SMALL  
6 GROUP Medical Mutual Plan must provide plan benefits for SUD and/or  
7 mental health treatment at no less than the amount required by law of UCR,  
8 notwithstanding patient copay and deductible obligations as set forth in the  
9 plan documents.

10 g. CONCAST BIRMINGHAM, INC. plan (the “**CONCAST**  
11 **Medical Mutual Plan**”). As required under the ACA and ERISA, the  
12 CONCAST Medical Mutual Plan must provide plan benefits for SUD and/or  
13 mental health treatment at no less than the amount required by law of UCR,  
14 notwithstanding patient copay and deductible obligations as set forth in the  
15 plan documents.

16 h. The PPO Network Comprehensive 1 Medical Mutual Plan, the  
17 PPO Network Comprehensive 2 Medical Mutual Plan, the OPERS Medical  
18 Mutual Plan, the COSE Medical Mutual Plan, the IP/MM/OFF Medical  
19 Mutual Plan, the SMALL GROUP Medical Mutual Plan, and the  
20 CONCAST Medical Mutual Plan shall sometimes be referred to collectively  
21 as the “**Medical Mutual Plans**”.

22 **280.** Plaintiff is informed and believes, and based thereon alleges, that for  
23 each of these claims and for each of the involved Patients, Medical Mutual has  
24 failed and refused to pay, process or adjust these claims in an appropriate fashion  
25 by, among other acts and omissions:

26 a. Delaying the processing, adjustment and/or payment of  
27 claims for periods of time greater than 45 days after submission of the  
28 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);



1           **b.**     Failing and refusing to provide any notice and/or  
2           explanation for the denial of benefits, payments or reimbursement of  
3           the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

4           **c.**     Failing and refusing to provide an adequate notice and/or  
5           explanation for the denial of benefits, payments or reimbursement of  
6           claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

7           **d.**     Failing and refusing to provide an explanation for the  
8           denial of benefits, payments or reimbursements of claims of each of  
9           the Patients, and by failing and refusing to set forth the specific reasons  
10          for such denials, all in violation of 29 U.S.C. § 1133(1);

11          **e.**     Failing and refusing to provide an explanation for the  
12          denial of benefits, payments or reimbursements of claims of each of  
13          the Patients, written in a manner calculated to be understood by the  
14          participant, in violation of 29 U.S.C. § 1133(1);

15          **f.**     Failing to afford Plaintiff and/or its Patients with a  
16          reasonable opportunity to engage in an appeals process, in violation of  
17          29 U.S.C. § 1133(2);

18          **g.**     Failing to afford Plaintiff and/or its Patients with a  
19          reasonable opportunity to engage in meaningful appeal process which  
20          was full and fair, in violation of 29 U.S.C. § 1133(2);

21          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
22          with information pertaining to their rights to appeal, including not  
23          limited to those deadlines for filing appeals and/or the requirements  
24          that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

25          **i.**     Violating the minimum requirements for employee benefit  
26          plans pertaining to claims and benefits by participants and  
27          beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;  
28

1           **j.**     Failing and refusing to establish and maintain reasonable  
2     claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

3           **k.**     Establishing, maintaining and enforcing claims  
4     procedures which unduly inhibit the initiation and processing of claims  
5     for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

6           **l.**     Precluding and prohibiting Plaintiff from acting as an  
7     authorized representative of the Patients in pursuing a benefit claim or  
8     appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
9     2560.503-1(b)(4);

10          **m.**    Failing and refusing to design, administer and enforce  
11    their processes, procedures and claims administration to ensure that  
12    their governing plan documents and provisions have been applied  
13    consistently with respect to similarly situated participants, beneficiaries  
14    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

15          **n.**    Failing and refusing to pay benefits for authorized  
16    services rendered by Plaintiff;

17          **o.**    Failing to offer coverage for mental health and SUD  
18    treatment in parity with the medical and surgical benefits afforded by  
19    the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
20    mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

21          **p.**    Failing and refusing to pay Plaintiff for the SUD  
22    treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

23       **281.**    The failure and refusal of Medical Mutual to provide coverage,  
24    reimbursement, payment and/or benefits for the SUD and/or mental health  
25    treatment benefits rendered by Morningside to Plaintiff's patients who were  
26    covered by Medical Mutual and Medical Mutual of health insurance benefits  
27    coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
28    between Medical Mutual and the Patients at issue in this lawsuit.

1           **282.** Medical Mutual has arbitrarily and capriciously breached the  
2 obligations set forth in the ERISA Plans issued by Medical Mutual and Medical  
3 Mutual vas arbitrarily and capriciously breached their obligations under the ERISA  
4 Plans to provide Plaintiff and that as a direct and proximate result of the actions by  
5 Medical Mutual, Plaintiff has been damaged in an amount equal to the amount of  
6 benefits Plaintiff should have received and to which the Patients would have been  
7 entitled had Medical Mutual paid the proper amounts, which Plaintiff estimates to  
8 be \$1,698,911.64.

9           **283.** As a direct and proximate result of the aforesaid conduct of Medical  
10 Mutual in failing to provide coverage as required, Plaintiff has suffered, and will  
11 continue to suffer in the future, damages, plus interest and other economic and  
12 consequential damages, for a total amount Plaintiff estimates to be \$1,698,911.64,  
13 or as otherwise determined at the time of trial.

14           **284.** Plaintiff is entitled to an award of statutory penalties in the amount to  
15 be determined at the time of trial against Medical Mutual.

16           **285.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
17 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the Medical  
18 Mutual, Plaintiff has retained the services of legal counsel and has necessarily  
19 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
20 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
21 action

22                                   **SIXTEENTH CLAIM FOR RELIEF**

23                           **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

24                                   **Against First Health)**

25           **286.** Plaintiff realleges and incorporates by reference each and every  
26 paragraph of this Complaint as though set forth herein.

27           **287.** This claim is alleged by Plaintiff for relief in connection with claims  
28 for treatment rendered to members of an ERISA Plan. This claim seeks to recover

1 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
2 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
3 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
4 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
5 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

6       **288.** Plaintiff is informed and believes, and based thereon alleges, that First  
7 Health is the insurer, sponsor, and/or financially responsible payer, serve as a  
8 designated plan administrator, and/or services as the named plan administrator's  
9 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
10 with respect to each of the ERISA Plans at issue in this case that are self-insured  
11 plans, but which do not specifically designate a plan administrator, First Health  
12 effectively controls the decision whether to honor or deny the a claim under the  
13 Plan, exercise authority over the resolution of benefits claims, and/or have  
14 responsibility to pay the claims. First Health also plays the role as the *de facto*  
15 plan administrator for such ERISA Plans.

16       **289.** With respect to the ERISA Plans relating to First Health, Plaintiff's  
17 claims against First Health include 1 patient of Morningside. To date, there  
18 remains a balance due and owing by First Health to Plaintiff in the amount of  
19 \$46,702.13.

20       **290.** Plaintiff is informed and believes, and based thereon alleges, that for  
21 each of these claims and for each of the involved Patients, First Health has failed  
22 and refused to pay, process or adjust these claims in an appropriate fashion by,  
23 among other acts and omissions:

24           **a.** Delaying the processing, adjustment and/or payment of  
25 claims for periods of time greater than 45 days after submission of the  
26 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);  
27  
28

1           **b.**     Failing and refusing to provide any notice and/or  
2           explanation for the denial of benefits, payments or reimbursement of  
3           the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

4           **c.**     Failing and refusing to provide an adequate notice and/or  
5           explanation for the denial of benefits, payments or reimbursement of  
6           claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

7           **d.**     Failing and refusing to provide an explanation for the  
8           denial of benefits, payments or reimbursements of claims of each of  
9           the Patients, and by failing and refusing to set forth the specific reasons  
10          for such denials, all in violation of 29 U.S.C. § 1133(1);

11          **e.**     Failing and refusing to provide an explanation for the  
12          denial of benefits, payments or reimbursements of claims of each of  
13          the Patients, written in a manner calculated to be understood by the  
14          participant, in violation of 29 U.S.C. § 1133(1);

15          **f.**     Failing to afford Plaintiff and/or its Patients with a  
16          reasonable opportunity to engage in an appeals process, in violation of  
17          29 U.S.C. § 1133(2);

18          **g.**     Failing to afford Plaintiff and/or its Patients with a  
19          reasonable opportunity to engage in meaningful appeal process which  
20          was full and fair, in violation of 29 U.S.C. § 1133(2);

21          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
22          with information pertaining to their rights to appeal, including not  
23          limited to those deadlines for filing appeals and/or the requirements  
24          that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

25          **i.**     Violating the minimum requirements for employee benefit  
26          plans pertaining to claims and benefits by participants and  
27          beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;  
28

1           **j.**     Failing and refusing to establish and maintain reasonable  
2     claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

3           **k.**     Establishing, maintaining and enforcing claims  
4     procedures which unduly inhibit the initiation and processing of claims  
5     for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

6           **l.**     Precluding and prohibiting Plaintiff from acting as an  
7     authorized representative of the Patients in pursuing a benefit claim or  
8     appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
9     2560.503-1(b)(4);

10          **m.**    Failing and refusing to design, administer and enforce  
11    their processes, procedures and claims administration to ensure that  
12    their governing plan documents and provisions have been applied  
13    consistently with respect to similarly situated participants, beneficiaries  
14    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

15          **n.**     Failing and refusing to pay benefits for authorized  
16    services rendered by Plaintiff;

17          **o.**     Failing to offer coverage for mental health and SUD  
18    treatment in parity with the medical and surgical benefits afforded by  
19    the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
20    mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

21          **p.**     Failing and refusing to pay Plaintiff for the SUD  
22    treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

23       **291.**    The failure and refusal of First Health to provide coverage,  
24    reimbursement, payment and/or benefits for the SUD and/or mental health  
25    treatment benefits rendered by Morningside to Plaintiff's patients who were  
26    covered by First Health and First Health denial of health insurance benefits  
27    coverage constitutes a breach of the insurance plans and/or employee benefit Plans  
28    between First Health and the Patients at issue in this lawsuit.

1       **292.** First Health has arbitrarily and capriciously breached the obligations  
2 set forth in the ERISA Plans issued by First Health and First Health has arbitrarily  
3 and capriciously breached their obligations under the ERISA Plans to provide  
4 Plaintiff and that as a direct and proximate result of the actions by Defendants,  
5 Plaintiff has been damaged in an amount equal to the amount of benefits Plaintiff  
6 should have received and to which the Patients would have been entitled had First  
7 Health paid the proper amounts, which Plaintiff estimates to be \$46,702.13

8       **293.** As a direct and proximate result of the aforesaid conduct of First  
9 Health in failing to provide coverage as required, Plaintiff has suffered, and will  
10 continue to suffer in the future, damages, plus interest and other economic and  
11 consequential damages, for a total amount Plaintiff estimates to be \$46,702.13, or  
12 as otherwise determined at the time of trial.

13       **294.** Plaintiff is entitled to an award of statutory penalties in the amount to  
14 be determined at the time of trial against First Health.

15       **295.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
16 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the 46,702.13,  
17 Plaintiff has retained the services of legal counsel and has necessarily incurred  
18 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
19 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
20 action.

21                               **SEVENTEENTH CLAIM FOR RELIEF**

22                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

23                               **Against BCBS Arkansas)**

24       **296.** Plaintiff realleges and incorporates by reference each and every  
25 paragraph of this Complaint as though set forth herein.

26       **297.** This claim is alleged by Plaintiff for relief in connection with claims  
27 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
28 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §



1 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
2 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
3 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
4 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

5 **298.** Plaintiff is informed and believes, and based thereon alleges, that  
6 BCBS Arkansas is the insurer, sponsor, and/or financially responsible payer, serve  
7 as a designated plan administrator, and/or services as the named plan  
8 administrator's designee. Plaintiff is further informed and believes, and based  
9 thereon alleges, that with respect to each of the ERISA Plans at issue in this case  
10 that are self-insured plans, but which do not specifically designate a plan  
11 administrator, BCBS Arkansas effectively controls the decision whether to honor  
12 or deny the a claim under the ERISA Plans, exercise authority over the resolution  
13 of benefits claims, and/or have responsibility to pay the claims. BCBS Arkansas  
14 also plays the role as the *de facto* plan administrator for such ERISA Plans.

15 **299.** With respect to the ERISA Plans relating to BCBS Arkansas,  
16 Plaintiff's claims against BCBS Arkansas include 11 patients of Morningside. To  
17 date, there remains a balance due and owing by BCBS Arkansas to Plaintiff in the  
18 amount of \$1,016,780.99.

19 **300.** The individual patient claims relating to BCBS Arkansas include the  
20 following:

21 **a.** Patient MC, with a balance due and owing to Plaintiff in the  
22 amount of \$77,034.00.

23 **b.** Patient CC, with a balance due and owing to Plaintiff in the  
24 amount of \$218,105.28.

25 **c.** Patient RH, with a balance due and owing to Plaintiff in the  
26 amount of \$20,129.79.

27 **d.** Patient CJ, with a balance due and owing to Plaintiff in the  
28 amount of \$4,978.00.

1           e.     Patient MK, with a balance due and owing to Plaintiff in the  
2     amount of \$15,230.85.

3           f.     Patient ML, with a balance due and owing to Plaintiff in the  
4     amount of \$9,928.20.

5           g.     Patient TM, with a balance due and owing to Plaintiff in the  
6     amount of \$70,180.56.

7           h.     Patient SL, with a balance due and owing to Plaintiff in the  
8     amount of \$360,902.75.

9           i.     Patient JN, with a balance due and owing to Plaintiff in the  
10    amount of \$133,715.08.

11          j.     Patient ER, with a balance due and owing to Plaintiff in the  
12    amount of \$83,813.23.

13          k.     Patient MS, with a balance due and owing to Plaintiff in the  
14    amount of \$22,493.25.

15       **301.** Plaintiff is informed and believes, and based thereon alleges, that for  
16 each of these claims and for each of the involved Patients, BCBS Arkansas has  
17 failed and refused to pay, process or adjust these claims in an appropriate fashion  
18 by, among other acts and omissions:

19           a.     Delaying the processing, adjustment and/or payment of  
20     claims for periods of time greater than 45 days after submission of the  
21     claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

22           b.     Failing and refusing to provide any notice and/or  
23     explanation for the denial of benefits, payments or reimbursement of  
24     the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

25           c.     Failing and refusing to provide an adequate notice and/or  
26     explanation for the denial of benefits, payments or reimbursement of  
27     claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);  
28

1           **d.**     Failing and refusing to provide an explanation for the  
2     denial of benefits, payments or reimbursements of claims of each of  
3     the Patients, and by failing and refusing to set forth the specific reasons  
4     for such denials, all in violation of 29 U.S.C. § 1133(1);

5           **e.**     Failing and refusing to provide an explanation for the  
6     denial of benefits, payments or reimbursements of claims of each of  
7     the Patients, written in a manner calculated to be understood by the  
8     participant, in violation of 29 U.S.C. § 1133(1);

9           **f.**     Failing to afford Plaintiff and/or its Patients with a  
10    reasonable opportunity to engage in an appeals process, in violation of  
11    29 U.S.C. § 1133(2);

12          **g.**     Failing to afford Plaintiff and/or its Patients with a  
13    reasonable opportunity to engage in meaningful appeal process which  
14    was full and fair, in violation of 29 U.S.C. § 1133(2);

15          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
16    with information pertaining to their rights to appeal, including not  
17    limited to those deadlines for filing appeals and/or the requirements  
18    that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

19          **i.**     Violating the minimum requirements for employee benefit  
20    plans pertaining to claims and benefits by participants and  
21    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

22          **j.**     Failing and refusing to establish and maintain reasonable  
23    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

24          **k.**     Establishing, maintaining and enforcing claims  
25    procedures which unduly inhibit the initiation and processing of claims  
26    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

27          **l.**     Precluding and prohibiting Plaintiff from acting as an  
28    authorized representative of the Patients in pursuing a benefit claim or

1 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
2 2560.503-1(b)(4);

3 m. Failing and refusing to design, administer and enforce  
4 their processes, procedures and claims administration to ensure that  
5 their governing plan documents and provisions have been applied  
6 consistently with respect to similarly situated participants, beneficiaries  
7 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

8 n. Failing and refusing to pay benefits for authorized  
9 services rendered by Plaintiff;

10 o. Failing to offer coverage for mental health and SUD  
11 treatment in parity with the medical and surgical benefits afforded by  
12 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
13 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

14 p. Failing and refusing to pay Plaintiff for the SUD  
15 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

16 **302.** The failure and refusal of BCBS Arkansas to provide coverage,  
17 reimbursement, payment and/or benefits for the SUD and/or mental health  
18 treatment benefits rendered by Morningside to Plaintiff's patients who were  
19 covered by BCBS Arkansas and BCBS Arkansas denial of health insurance  
20 benefits coverage constitutes a breach of the insurance plans and/or employee  
21 benefit Plans between BCBS Arkansas and the Patients at issue in this lawsuit.

22 **303.** BCBS Arkansas has arbitrarily and capriciously breached the  
23 obligations set forth in the ERISA Plans issued by BCBS Arkansas and BCBS  
24 Arkansas has arbitrarily and capriciously breached their obligations under the  
25 ERISA Plans to provide Plaintiff and that as a direct and proximate result of the  
26 actions by Defendants, Plaintiff has been damaged in an amount equal to the  
27 amount of benefits Plaintiff should have received and to which the Patients would  
28

1 have been entitled had BCBS Arkansas paid the proper amounts, which Plaintiff  
2 estimates to be \$1,016,780.99.

3       **304.** As a direct and proximate result of the aforesaid conduct of BCBS  
4 Arkansas in failing to provide coverage as required, Plaintiff has suffered, and will  
5 continue to suffer in the future, damages, plus interest and other economic and  
6 consequential damages, for a total amount Plaintiff estimates to be \$1,016,780.99,  
7 or as otherwise determined at the time of trial.

8       **305.** Plaintiff is entitled to an award of statutory penalties in the amount to  
9 be determined at the time of trial against BCBS Arkansas.

10       **306.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
11 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of BCBS  
12 Arkansas, Plaintiff has retained the services of legal counsel and has necessarily  
13 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
14 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
15 action.

16                   **EIGHTEENTH CLAIM FOR RELIEF**

17                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**  
18                   **Against Coventry)**

19       **307.** Plaintiff realleges and incorporates by reference each and every  
20 paragraph of this Complaint as though set forth herein.

21       **308.** This claim is alleged by Plaintiff for relief in connection with claims  
22 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
23 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
24 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
25 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
26 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
27 of the ERISA Plans, and is the "claimant" for purposes of ERISA.  
28

1           **309.** Plaintiff is informed and believes, and based thereon alleges, that  
2 Coventry is the insurer, sponsor, and/or financially responsible payer, serve as a  
3 designated plan administrator, and/or services as the named plan administrator's  
4 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
5 with respect to each of the ERISA Plans at issue in this case that are self-insured  
6 plans, but which do not specifically designate a plan administrator, Coventry  
7 effectively controls the decision whether to honor or deny the a claim under the  
8 ERISA Plans, exercise authority over the resolution of benefits claims, and/or have  
9 responsibility to pay the claims. Coventry also plays the role as the *de facto* plan  
10 administrator for such ERISA Plans.

11           **310.** With respect to the ERISA Plans relating to Coventry, Plaintiff's  
12 claims against Coventry include 6 patients of Morningside. To date, there remains  
13 a balance due and owing by Coventry to Plaintiff in the amount of \$471,554.58.

14           **311.** Coventry has not provided Plaintiff with any plan documents, nor has  
15 Coventry disclosed to Plaintiff the Coventry patients at issue falling under an  
16 ERISA Plan or not, so in an abundance of caution, Plaintiff lists all claims against  
17 Coventry at this time. Plaintiff's individual patient claims relating to Coventry  
18 include the following:

19                   **a.** Patient TC, with a balance due and owing to Plaintiff in the  
20 amount of \$289,113.97.

21                   **b.** Patient MC, with a balance due and owing to Plaintiff in the  
22 amount of \$45,082.66.

23                   **c.** Patient KC, with a balance due and owing to Plaintiff in the  
24 amount of \$67,534.37.

25                   **d.** Patient CH, with a balance due and owing to Plaintiff in the  
26 amount of \$35,280.00.

27                   **e.** Patient MR, with a balance due and owing to Plaintiff in the  
28 amount of \$29,441.16.

1           **f.**     Patient DR, with a balance due and owing to Plaintiff in the  
2     amount of \$5,092.42

3           **312.** Plaintiff is informed and believes, and based thereon alleges, that for  
4     each of these claims and for each of the involved Patients, Coventry has failed and  
5     refused to pay, process or adjust these claims in an appropriate fashion by, among  
6     other acts and omissions:

7           **a.**     Delaying the processing, adjustment and/or payment of  
8     claims for periods of time greater than 45 days after submission of the  
9     claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

10          **b.**     Failing and refusing to provide any notice and/or  
11     explanation for the denial of benefits, payments or reimbursement of  
12     the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

13          **c.**     Failing and refusing to provide an adequate notice and/or  
14     explanation for the denial of benefits, payments or reimbursement of  
15     claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

16          **d.**     Failing and refusing to provide an explanation for the  
17     denial of benefits, payments or reimbursements of claims of each of  
18     the Patients, and by failing and refusing to set forth the specific reasons  
19     for such denials, all in violation of 29 U.S.C. § 1133(1);

20          **e.**     Failing and refusing to provide an explanation for the  
21     denial of benefits, payments or reimbursements of claims of each of  
22     the Patients, written in a manner calculated to be understood by the  
23     participant, in violation of 29 U.S.C. § 1133(1);

24          **f.**     Failing to afford Plaintiff and/or its Patients with a  
25     reasonable opportunity to engage in an appeals process, in violation of  
26     29 U.S.C. § 1133(2);



1           **g.**     Failing to afford Plaintiff and/or its Patients with a  
2     reasonable opportunity to engage in meaningful appeal process which  
3     was full and fair, in violation of 29 U.S.C. § 1133(2);

4           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
5     with information pertaining to their rights to appeal, including not  
6     limited to those deadlines for filing appeals and/or the requirements  
7     that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

8           **i.**     Violating the minimum requirements for employee benefit  
9     plans pertaining to claims and benefits by participants and  
10    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

11          **j.**     Failing and refusing to establish and maintain reasonable  
12    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

13          **k.**     Establishing, maintaining and enforcing claims  
14    procedures which unduly inhibit the initiation and processing of claims  
15    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

16          **l.**     Precluding and prohibiting Plaintiff from acting as an  
17    authorized representative of the Patients in pursuing a benefit claim or  
18    appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
19    2560.503-1(b)(4);

20          **m.**     Failing and refusing to design, administer and enforce  
21    their processes, procedures and claims administration to ensure that  
22    their governing plan documents and provisions have been applied  
23    consistently with respect to similarly situated participants, beneficiaries  
24    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

25          **n.**     Failing and refusing to pay benefits for authorized  
26    services rendered by Plaintiff;

27          **o.**     Failing to offer coverage for mental health and SUD  
28    treatment in parity with the medical and surgical benefits afforded by

1 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
2 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

3 p. Failing and refusing to pay Plaintiff for the SUD  
4 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

5 **313.** The failure and refusal of Coventry to provide coverage,  
6 reimbursement, payment and/or benefits for the SUD and/or mental health  
7 treatment benefits rendered by Morningside to Plaintiff's patients who were  
8 covered by Coventry and Coventry's denial of health insurance benefits coverage  
9 constitutes a breach of the insurance plans and/or employee benefit Plans between  
10 BCBS Arkansas and the Patients at issue in this lawsuit.

11 **314.** Coventry has arbitrarily and capriciously breached the obligations set  
12 forth in the ERISA Plans issued by Coventry and Coventry has arbitrarily and  
13 capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
14 and that as a direct and proximate result of the actions by Defendants, Plaintiff has  
15 been damaged in an amount equal to the amount of benefits Plaintiff should have  
16 received and to which the Patients would have been entitled had Coventry paid the  
17 proper amounts, which Plaintiff estimates to be \$471,554.58.

18 **315.** As a direct and proximate result of the aforesaid conduct of Coventry  
19 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
20 to suffer in the future, damages, plus interest and other economic and  
21 consequential damages, for a total amount Plaintiff estimates to be \$471,554.58, or  
22 as otherwise determined at the time of trial.

23 **316.** Plaintiff is entitled to an award of statutory penalties in the amount to  
24 be determined at the time of trial against Coventry.

25 **317.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
26 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of Coventry,  
27 Plaintiff has retained the services of legal counsel and has necessarily incurred  
28 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff

1 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
2 action.

3 **NINETEENTH CLAIM FOR RELIEF**

4 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

5 **Against Group Health Plan)**

6 **318.** Plaintiff realleges and incorporates by reference each and every  
7 paragraph of this Complaint as though set forth herein.

8 **319.** This claim is alleged by Plaintiff for relief in connection with claims  
9 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
10 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
11 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
12 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
13 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
14 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

15 **320.** Plaintiff is informed and believes, and based thereon alleges, that  
16 Group Health Plan is the insurer, sponsor, and/or financially responsible payer,  
17 serve as a designated plan administrator, and/or services as the named plan  
18 administrator's designee. Plaintiff is further informed and believes, and based  
19 thereon alleges, that with respect to each of the ERISA Plans at issue in this case  
20 that are self-insured plans, but which do not specifically designate a plan  
21 administrator, Group Health Plan effectively controls the decision whether to  
22 honor or deny the a claim under the ERISA Plans, exercise authority over the  
23 resolution of benefits claims, and/or have responsibility to pay the claims. Group  
24 Health Plan also plays the role as the *de facto* plan administrator for such ERISA  
25 Plans.

26 **321.** With respect to the ERISA Plans relating to Group Health Plan,  
27 Plaintiff's claims against Group Health Plan include 4 patients of Morningside. To  
28

1 date, there remains a balance due and owing by Coventry to Plaintiff in the amount  
2 of \$273,212.78.

3 **322.** Group Health Plan has not provided Plaintiff with any plan  
4 documents, nor has Group Health Plan disclosed to Plaintiff the Group Health Plan  
5 patients at issue falling under an ERISA Plan or not, so in an abundance of caution,  
6 Plaintiff lists all claims against Group Health Plan at this time. Plaintiff's  
7 individual patient claims relating to Group Health Plan include the following:

8 **a.** Patient RD, with a balance due and owing to Plaintiff in the  
9 amount of \$41,341.09.

10 **b.** Patient ME, with a balance due and owing to Plaintiff in the  
11 amount of \$9,165.00.

12 **c.** Patient JP, with a balance due and owing to Plaintiff in the  
13 amount of \$96,591.46.

14 **d.** Patient TR, with a balance due and owing to Plaintiff in the  
15 amount of \$126,115.23.

16 **323.** Plaintiff is informed and believes, and based thereon alleges, that for  
17 each of these claims and for each of the involved Patients, Group Health Plan has  
18 failed and refused to pay, process or adjust these claims in an appropriate fashion  
19 by, among other acts and omissions:

20 **a.** Delaying the processing, adjustment and/or payment of  
21 claims for periods of time greater than 45 days after submission of the  
22 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

23 **b.** Failing and refusing to provide any notice and/or  
24 explanation for the denial of benefits, payments or reimbursement of  
25 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

26 **c.** Failing and refusing to provide an adequate notice and/or  
27 explanation for the denial of benefits, payments or reimbursement of  
28 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

1           **d.**     Failing and refusing to provide an explanation for the  
2     denial of benefits, payments or reimbursements of claims of each of  
3     the Patients, and by failing and refusing to set forth the specific reasons  
4     for such denials, all in violation of 29 U.S.C. § 1133(1);

5           **e.**     Failing and refusing to provide an explanation for the  
6     denial of benefits, payments or reimbursements of claims of each of  
7     the Patients, written in a manner calculated to be understood by the  
8     participant, in violation of 29 U.S.C. § 1133(1);

9           **f.**     Failing to afford Plaintiff and/or its Patients with a  
10    reasonable opportunity to engage in an appeals process, in violation of  
11    29 U.S.C. § 1133(2);

12          **g.**     Failing to afford Plaintiff and/or its Patients with a  
13    reasonable opportunity to engage in meaningful appeal process which  
14    was full and fair, in violation of 29 U.S.C. § 1133(2);

15          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
16    with information pertaining to their rights to appeal, including not  
17    limited to those deadlines for filing appeals and/or the requirements  
18    that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

19          **i.**     Violating the minimum requirements for employee benefit  
20    plans pertaining to claims and benefits by participants and  
21    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

22          **j.**     Failing and refusing to establish and maintain reasonable  
23    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

24          **k.**     Establishing, maintaining and enforcing claims  
25    procedures which unduly inhibit the initiation and processing of claims  
26    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

27          **l.**     Precluding and prohibiting Plaintiff from acting as an  
28    authorized representative of the Patients in pursuing a benefit claim or

1 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
2 2560.503-1(b)(4);

3 m. Failing and refusing to design, administer and enforce  
4 their processes, procedures and claims administration to ensure that  
5 their governing plan documents and provisions have been applied  
6 consistently with respect to similarly situated participants, beneficiaries  
7 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

8 n. Failing and refusing to pay benefits for authorized  
9 services rendered by Plaintiff;

10 o. Failing to offer coverage for mental health and SUD  
11 treatment in parity with the medical and surgical benefits afforded by  
12 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
13 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

14 p. Failing and refusing to pay Plaintiff for the SUD  
15 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

16 **324.** The failure and refusal of Group Health Plan to provide coverage,  
17 reimbursement, payment and/or benefits for the SUD and/or mental health  
18 treatment benefits rendered by Morningside to Plaintiff's patients who were  
19 covered by Group Health Plan and Group Health Plan's denial of health insurance  
20 benefits coverage constitutes a breach of the insurance plans and/or employee  
21 benefit Plans between Group Health Plan and the Patients at issue in this lawsuit.

22 **325.** Group Health Plan has arbitrarily and capriciously breached the  
23 obligations set forth in the ERISA Plans issued by Group Health Plan and Group  
24 Health Plan has arbitrarily and capriciously breached their obligations under the  
25 ERISA Plans to provide Plaintiff and that as a direct and proximate result of the  
26 actions by Defendants, Plaintiff has been damaged in an amount equal to the  
27 amount of benefits Plaintiff should have received and to which the Patients would  
28

1 have been entitled had Group Health Plan paid the proper amounts, which Plaintiff  
2 estimates to be \$273,212.78.

3       **326.** As a direct and proximate result of the aforesaid conduct of Group  
4 Health Plan in failing to provide coverage as required, Plaintiff has suffered, and  
5 will continue to suffer in the future, damages, plus interest and other economic and  
6 consequential damages, for a total amount Plaintiff estimates to be \$273,212.78, or  
7 as otherwise determined at the time of trial.

8       **327.** Plaintiff is entitled to an award of statutory penalties in the amount to  
9 be determined at the time of trial against Group Health Plan.

10       **328.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
11 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of Group Health  
12 Plan, Plaintiff has retained the services of legal counsel and has necessarily  
13 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
14 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
15 action.

16                               **TWENTIETH CLAIM FOR RELIEF**

17                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

18                               **Against the Cigna Defendants)**

19       **329.** Plaintiff realleges and incorporates by reference each and every  
20 paragraph of this Complaint as though set forth herein.

21       **330.** This claim is alleged by Plaintiff for relief in connection with claims  
22 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
23 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
24 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
25 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
26 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
27 of the ERISA Plans, and is the "claimant" for purposes of ERISA.  
28



1           **331.** Plaintiff is informed and believes, and based thereon alleges, that the  
2 Cigna Defendants are the insurer, sponsor, and/or financially responsible payer,  
3 serve as a designated plan administrator, and/or services as the named plan  
4 administrator's designee. Plaintiff is further informed and believes, and based  
5 thereon alleges, that with respect to each of the ERISA Plans at issue in this case  
6 that are self-insured plans, but which do not specifically designate a plan  
7 administrator, the Cigna Defendants effectively control the decision whether to  
8 honor or deny a claim under the ERISA Plans, exercise authority over the  
9 resolution of benefits claims, and/or have responsibility to pay the claims. The  
10 Cigna Defendants also play the role as the *de facto* plan administrator for such  
11 ERISA Plans.

12           **332.** With respect to the patient information relating to the Cigna  
13 Defendants, a list of Plaintiff's claims against the Cigna Defendants are  
14 concurrently filed under seal as Exhibit F and incorporated herein by this  
15 reference.

16           **333.** The Cigna Defendants have not provided Plaintiff with information  
17 about which of these claims fall under an ERISA Plan and which ones do not, so in  
18 an abundance of caution, Plaintiff lists all claims against the Anthem Defendants at  
19 this time. To date, there remains a balance due and owing by the Cigna  
20 Defendants to Plaintiff in the amount of \$10,055,275.66.

21           **334.** The Cigna Defendants provided Plaintiff with copies of a few plan  
22 documents in connection with the Cigna Defendants' motion to dismiss. Plaintiff is  
23 informed and believes, and based thereon alleges, that the total number of patients  
24 and plans applicable to the Cigna Defendants may exceed 200.

25           **335.** Plaintiff is informed and believes, and based thereon alleges, that for  
26 each of these claims and for each of the involved Patients, the Cigna Defendants  
27 have failed and refused to pay, process or adjust these claims in an appropriate  
28 fashion by, among other acts and omissions:

1           **a.**     Delaying the processing, adjustment and/or payment of  
2           claims for periods of time greater than 45 days after submission of the  
3           claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

4           **b.**     Failing and refusing to provide any notice and/or  
5           explanation for the denial of benefits, payments or reimbursement of  
6           the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

7           **c.**     Failing and refusing to provide an adequate notice and/or  
8           explanation for the denial of benefits, payments or reimbursement of  
9           claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

10          **d.**     Failing and refusing to provide an explanation for the  
11          denial of benefits, payments or reimbursements of claims of each of  
12          the Patients, and by failing and refusing to set forth the specific reasons  
13          for such denials, all in violation of 29 U.S.C. § 1133(1);

14          **e.**     Failing and refusing to provide an explanation for the  
15          denial of benefits, payments or reimbursements of claims of each of  
16          the Patients, written in a manner calculated to be understood by the  
17          participant, in violation of 29 U.S.C. § 1133(1);

18          **f.**     Failing to afford Plaintiff and/or its Patients with a  
19          reasonable opportunity to engage in an appeals process, in violation of  
20          29 U.S.C. § 1133(2);

21          **g.**     Failing to afford Plaintiff and/or its Patients with a  
22          reasonable opportunity to engage in meaningful appeal process which  
23          was full and fair, in violation of 29 U.S.C. § 1133(2);

24          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
25          with information pertaining to their rights to appeal, including not  
26          limited to those deadlines for filing appeals and/or the requirements  
27          that an appeal be filed, in violation of 29 U.S.C. § 1133(1);  
28

1           **i.**       Violating the minimum requirements for employee benefit  
2 plans pertaining to claims and benefits by participants and  
3 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

4           **j.**       Failing and refusing to establish and maintain reasonable  
5 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

6           **k.**       Establishing, maintaining and enforcing claims  
7 procedures which unduly inhibit the initiation and processing of claims  
8 for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

9           **l.**       Precluding and prohibiting Plaintiff from acting as an  
10 authorized representative of the Patients in pursuing a benefit claim or  
11 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
12 2560.503-1(b)(4);

13           **m.**      Failing and refusing to design, administer and enforce  
14 their processes, procedures and claims administration to ensure that  
15 their governing plan documents and provisions have been applied  
16 consistently with respect to similarly situated participants, beneficiaries  
17 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

18           **n.**       Failing and refusing to pay benefits for authorized  
19 services rendered by Plaintiff;

20           **o.**       Failing to offer coverage for mental health and SUD  
21 treatment in parity with the medical and surgical benefits afforded by  
22 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
23 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

24           **p.**       Failing and refusing to pay Plaintiff for the SUD  
25 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

26       **336.** The failure and refusal of the Cigna Defendants to provide coverage,  
27 reimbursement, payment and/or benefits for the SUD and/or mental health  
28 treatment benefits rendered by Morningside to Plaintiff's patients who were

1 covered by the Cigna Defendants and the Cigna Defendants denial of health  
2 insurance benefits coverage constitutes a breach of the insurance plans and/or  
3 employee benefit Plans between the Cigna Defendants and the Patients at issue in  
4 this lawsuit.

5 **337.** The Cigna Defendants have arbitrarily and capriciously breached the  
6 obligations set forth in the ERISA Plans issued by the Cigna Defendants and the  
7 Cigna Defendants has arbitrarily and capriciously breached their obligations under  
8 the ERISA Plans to provide Plaintiff and that as a direct and proximate result of  
9 their actions, Plaintiff has been damaged in an amount equal to the amount of  
10 benefits Plaintiff should have received and to which the Patients would have been  
11 entitled had Coventry paid the proper amounts, which Plaintiff estimates to be  
12 \$10,055,275.66.

13 **338.** As a direct and proximate result of the aforesaid conduct of Coventry  
14 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
15 to suffer in the future, damages, plus interest and other economic and  
16 consequential damages, for a total amount Plaintiff estimates to be \$10,055,763.66,  
17 or as otherwise determined at the time of trial.

18 **339.** Plaintiff is entitled to an award of statutory penalties in the amount to  
19 be determined at the time of trial against the Cigna Defendants.

20 **340.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
21 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the Cigna  
22 Defendants, Plaintiff has retained the services of legal counsel and has necessarily  
23 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
24 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
25 action.  
26  
27  
28

**TWENTY-FIRST CLAIM FOR RELIEF**

**(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

**Against the Beacon Defendants)**

**341.** Plaintiff realleges and incorporates by reference each and every paragraph of this Complaint as though set forth herein.

**342.** This claim is alleged by Plaintiff for relief in connection with claims for treatment rendered to members of an ERISA Plan. This claim seeks to recover benefits, enforce rights and clarify rights to benefits under 29 U.S.C. § 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the Patients' benefits under the ERISA Plans. As the assignee of benefits under the ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms of the ERISA Plans, and is the "claimant" for purposes of ERISA.

**343.** Plaintiff is informed and believes, and based thereon alleges, that the Beacon Defendants are the insurer, sponsor, and/or financially responsible payer, serve as a designated plan administrator, and/or serves as the named plan administrator's designee. Plaintiff is further informed and believes, and based thereon alleges, that with respect to each of the ERISA Plans at issue in this case that are self-insured plans, but which do not specifically designate a plan administrator, the Beacon Defendants effectively control the decision whether to honor or deny the a claim under the ERISA Plans, exercise authority over the resolution of benefits claims, and/or have responsibility to pay the claims. The Beacon Defendants also play the role as the *de facto* plan administrator for such ERISA Plans.

**344.** With respect to the ERISA Plans relating to the Beacon Defendants, to date, there remains a balance due and owing by the Beacon Defendants to Plaintiff in the amount of \$1,192,890.55.

**345.** The Beacon Defendants have not provided Plaintiff with any plan documents, nor have the Beacon Defendants disclosed to Plaintiff the Beacon

1 patients at issue falling under an ERISA Plan or not, so in an abundance of caution,  
2 Plaintiff lists all claims against the Beacon Defendants at this time.

3       **346.** Plaintiff is informed and believes, and based thereon alleges, that for  
4 each of these claims and for each of the involved Patients, the Beacon Defendants  
5 have failed and refused to pay, process or adjust these claims in an appropriate  
6 fashion by, among other acts and omissions:

7               **a.**     Delaying the processing, adjustment and/or payment of  
8 claims for periods of time greater than 45 days after submission of the  
9 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

10              **b.**     Failing and refusing to provide any notice and/or  
11 explanation for the denial of benefits, payments or reimbursement of  
12 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

13              **c.**     Failing and refusing to provide an adequate notice and/or  
14 explanation for the denial of benefits, payments or reimbursement of  
15 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

16              **d.**     Failing and refusing to provide an explanation for the  
17 denial of benefits, payments or reimbursements of claims of each of  
18 the Patients, and by failing and refusing to set forth the specific reasons  
19 for such denials, all in violation of 29 U.S.C. § 1133(1);

20              **e.**     Failing and refusing to provide an explanation for the  
21 denial of benefits, payments or reimbursements of claims of each of  
22 the Patients, written in a manner calculated to be understood by the  
23 participant, in violation of 29 U.S.C. § 1133(1);

24              **f.**     Failing to afford Plaintiff and/or its Patients with a  
25 reasonable opportunity to engage in an appeals process, in violation of  
26 29 U.S.C. § 1133(2);

1           **g.**     Failing to afford Plaintiff and/or its Patients with a  
2     reasonable opportunity to engage in meaningful appeal process which  
3     was full and fair, in violation of 29 U.S.C. § 1133(2);

4           **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
5     with information pertaining to their rights to appeal, including not  
6     limited to those deadlines for filing appeals and/or the requirements  
7     that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

8           **i.**     Violating the minimum requirements for employee benefit  
9     plans pertaining to claims and benefits by participants and  
10    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

11          **j.**     Failing and refusing to establish and maintain reasonable  
12    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

13          **k.**     Establishing, maintaining and enforcing claims  
14    procedures which unduly inhibit the initiation and processing of claims  
15    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

16          **l.**     Precluding and prohibiting Plaintiff from acting as an  
17    authorized representative of the Patients in pursuing a benefit claim or  
18    appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
19    2560.503-1(b)(4);

20          **m.**     Failing and refusing to design, administer and enforce  
21    their processes, procedures and claims administration to ensure that  
22    their governing plan documents and provisions have been applied  
23    consistently with respect to similarly situated participants, beneficiaries  
24    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

25          **n.**     Failing and refusing to pay benefits for authorized  
26    services rendered by Plaintiff;

27          **o.**     Failing to offer coverage for mental health and SUD  
28    treatment in parity with the medical and surgical benefits afforded by



1 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
2 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

3 p. Failing and refusing to pay Plaintiff for the SUD  
4 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

5 **347.** The failure and refusal of the Beacon Defendants to provide coverage,  
6 reimbursement, payment and/or benefits for the SUD and/or mental health  
7 treatment benefits rendered by Morningside to Plaintiff's patients who were  
8 covered by the Beacon Defendants and the Beacon Defendants' denial of health  
9 insurance benefits coverage constitutes a breach of the insurance plans and/or  
10 employee benefit Plans between the Beacon Defendants and the Patients at issue in  
11 this lawsuit.

12 **348.** The Beacon Defendants have arbitrarily and capriciously breached the  
13 obligations set forth in the ERISA Plans issued by the Beacon Defendants and the  
14 Beacon Defendants have arbitrarily and capriciously breached their obligations  
15 under the ERISA Plans to provide Plaintiff and that as a direct and proximate result  
16 of their actions by the Beacon Defendants, Plaintiff has been damaged in an  
17 amount equal to the amount of benefits Plaintiff should have received and to which  
18 the Patients would have been entitled had the Beacon Defendants paid the proper  
19 amounts, which Plaintiff estimates to be \$1,192,80.55.

20 **349.** As a direct and proximate result of the aforesaid conduct of Coventry  
21 in failing to provide coverage as required, Plaintiff has suffered, and will continue  
22 to suffer in the future, damages, plus interest and other economic and  
23 consequential damages, for a total amount Plaintiff estimates to be \$1,192,80.55,  
24 or as otherwise determined at the time of trial.

25 **350.** Plaintiff is entitled to an award of statutory penalties in the amount to  
26 be determined at the time of trial against the Beacon Defendants.

27 **351.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
28 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the Beacon

1 Defendants, Plaintiff has retained the services of legal counsel and has necessarily  
2 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
3 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
4 action.

5 **TWENTY-SECOND CLAIM FOR RELIEF**

6 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

7 **Against the Anthem Defendants)**

8 **352.** Plaintiff realleges and incorporates by reference each and every  
9 paragraph of this Complaint as though set forth herein.

10 **353.** This claim is alleged by Plaintiff for relief in connection with claims  
11 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
12 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
13 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
14 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
15 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
16 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

17 **354.** Plaintiff is informed and believes, and based thereon alleges, that the  
18 Anthem Defendants are the insurer, sponsor, and/or financially responsible payer,  
19 serve as a designated plan administrator, and/or services as the named plan  
20 administrator's designee. Plaintiff is further informed and believes, and based  
21 thereon alleges, that with respect to each of the ERISA Plans at issue in this case  
22 that are self-insured plans, but which do not specifically designate a plan  
23 administrator, the Anthem Defendants effectively control the decision whether to  
24 honor or deny the a claim under the ERISA Plans, exercise authority over the  
25 resolution of benefits claims, and/or have responsibility to pay the claims. The  
26 Anthem Defendants also play the role as the *de facto* plan administrator for such  
27 ERISA Plans.

1           **355.** With respect to the patient information relating to the Anthem  
2 Defendants, a list of Plaintiff's claims against the Anthem Defendants are  
3 concurrently filed under seal as Exhibit G and incorporated herein by this  
4 reference. Counsel for Plaintiff sent a copy of this list of claims to counsel for the  
5 Anthem Defendants on August 16, 2019.

6           **356.** The Anthem Defendants have not provided Plaintiff with information  
7 about which of these claims fall under an ERISA Plan and which ones do not, so in  
8 an abundance of caution, Plaintiff lists all claims against the Anthem Defendants at  
9 this time. To date, there remains a balance due and owing by the Anthem  
10 Defendants to Plaintiff in the amount of \$54,057,080.22.

11           **357.** The Anthem Defendants provided Plaintiff with copies of  
12 approximately 30 plan documents in connection with the Anthem Defendants  
13 motion to dismiss. Plaintiff is informed and believes, and based thereon alleges,  
14 that the total number of patients and plants applicable to the Anthem Defendants  
15 may exceed 1,000.

16           **358.** Plaintiff is informed and believes, and based thereon alleges, that for  
17 each of these claims and for each of the involved Patients, the Anthem Defendants  
18 has failed and refused to pay, process or adjust these claims in an appropriate  
19 fashion by, among other acts and omissions:

20               **a.**     Delaying the processing, adjustment and/or payment of  
21 claims for periods of time greater than 45 days after submission of the  
22 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

23               **b.**     Failing and refusing to provide any notice and/or  
24 explanation for the denial of benefits, payments or reimbursement of  
25 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

26               **c.**     Failing and refusing to provide an adequate notice and/or  
27 explanation for the denial of benefits, payments or reimbursement of  
28 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

1           **d.**     Failing and refusing to provide an explanation for the  
2     denial of benefits, payments or reimbursements of claims of each of  
3     the Patients, and by failing and refusing to set forth the specific reasons  
4     for such denials, all in violation of 29 U.S.C. § 1133(1);

5           **e.**     Failing and refusing to provide an explanation for the  
6     denial of benefits, payments or reimbursements of claims of each of  
7     the Patients, written in a manner calculated to be understood by the  
8     participant, in violation of 29 U.S.C. § 1133(1);

9           **f.**     Failing to afford Plaintiff and/or its Patients with a  
10    reasonable opportunity to engage in an appeals process, in violation of  
11    29 U.S.C. § 1133(2);

12          **g.**     Failing to afford Plaintiff and/or its Patients with a  
13    reasonable opportunity to engage in meaningful appeal process which  
14    was full and fair, in violation of 29 U.S.C. § 1133(2);

15          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
16    with information pertaining to their rights to appeal, including not  
17    limited to those deadlines for filing appeals and/or the requirements  
18    that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

19          **i.**     Violating the minimum requirements for employee benefit  
20    plans pertaining to claims and benefits by participants and  
21    beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

22          **j.**     Failing and refusing to establish and maintain reasonable  
23    claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

24          **k.**     Establishing, maintaining and enforcing claims  
25    procedures which unduly inhibit the initiation and processing of claims  
26    for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

27          **l.**     Precluding and prohibiting Plaintiff from acting as an  
28    authorized representative of the Patients in pursuing a benefit claim or

1 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
2 2560.503-1(b)(4);

3 m. Failing and refusing to design, administer and enforce  
4 their processes, procedures and claims administration to ensure that  
5 their governing plan documents and provisions have been applied  
6 consistently with respect to similarly situated participants, beneficiaries  
7 and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

8 n. Failing and refusing to pay benefits for authorized  
9 services rendered by Plaintiff;

10 o. Failing to offer coverage for mental health and SUD  
11 treatment in parity with the medical and surgical benefits afforded by  
12 the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
13 mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

14 p. Failing and refusing to pay Plaintiff for the SUD  
15 treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

16 **359.** The failure and refusal of the Anthem Defendants to provide  
17 coverage, reimbursement, payment and/or benefits for the SUD and/or mental  
18 health treatment benefits rendered by Morningside to Plaintiff's patients who were  
19 covered by the Anthem Defendants and the Anthem Defendants' denial of health  
20 insurance benefits coverage constitutes a breach of the insurance plans and/or  
21 employee benefit Plans between the Anthem Defendants and the Patients at issue  
22 in this lawsuit.

23 **360.** The Anthem Defendants have arbitrarily and capriciously breached  
24 the obligations set forth in the ERISA Plans issued by the Anthem Defendants and  
25 the Anthem Defendants have arbitrarily and capriciously breached their obligations  
26 under the ERISA Plans to provide Plaintiff and that as a direct and proximate result  
27 of the their actions, Plaintiff has been damaged in an amount equal to the amount  
28 of benefits Plaintiff should have received and to which the Patients would have

1 been entitled had the Anthem Defendants paid the proper amounts, which Plaintiff  
2 estimates to be \$54,057,080.22.

3 **361.** As a direct and proximate result of the aforesaid conduct of the  
4 Anthem Defendants in failing to provide coverage as required, Plaintiff has  
5 suffered, and will continue to suffer in the future, damages, plus interest and other  
6 economic and consequential damages, for a total amount Plaintiff estimates to be  
7 \$54,057,080.22, or as otherwise determined at the time of trial.

8 **362.** Plaintiff is entitled to an award of statutory penalties in the amount to  
9 be determined at the time of trial against \$54,057,080.22.

10 **363.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
11 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of the Anthem  
12 Defendants, Plaintiff has retained the services of legal counsel and has necessarily  
13 incurred attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
14 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
15 action.

16 **TWENTY-THIRD CLAIM FOR RELIEF**

17 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B))**

18 **Against Aetna)**

19 **364.** Plaintiff realleges and incorporates by reference each and every  
20 paragraph of this Complaint as though set forth herein.

21 **365.** This claim is alleged by Plaintiff for relief in connection with claims  
22 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
23 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
24 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
25 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
26 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
27 of the ERISA Plans, and is the "claimant" for purposes of ERISA.  
28

1           **366.** Plaintiff is informed and believes, and based thereon alleges, that  
2 Aetna, as the insurer, sponsor, and/or financially responsible payer, serve as a  
3 designated plan administrator, and/or services as the named plan administrator's  
4 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
5 with respect to each of the ERISA Plans at issue in this case that are self-insured  
6 plans, but which do not specifically designate a plan administrator, Aetna  
7 effectively controls the decision whether to honor or deny the a claim under the  
8 ERISA Plans, exercise authority over the resolution of benefits claims, and/or have  
9 responsibility to pay the claims. Aetna also plays the role as the *de facto* plan  
10 administrator for such ERISA Plans.

11           **367.** With respect to the ERISA Plans relating to Aetna, Plaintiff's claims  
12 against Aetna include are due and owing by Aetna to Plaintiff in the amount of  
13 \$3,524,817.46.

14           **368.** Plaintiff is informed and believes, and based thereon alleges, that for  
15 each of these claims and for each of the involved Patients, Coventry has failed and  
16 refused to pay, process or adjust these claims in an appropriate fashion by, among  
17 other acts and omissions:

18                   **a.**     Delaying the processing, adjustment and/or payment of  
19 claims for periods of time greater than 45 days after submission of the  
20 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);

21                   **b.**     Failing and refusing to provide any notice and/or  
22 explanation for the denial of benefits, payments or reimbursement of  
23 the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

24                   **c.**     Failing and refusing to provide an adequate notice and/or  
25 explanation for the denial of benefits, payments or reimbursement of  
26 claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

27                   **d.**     Failing and refusing to provide an explanation for the  
28 denial of benefits, payments or reimbursements of claims of each of



1 the Patients, and by failing and refusing to set forth the specific reasons  
2 for such denials, all in violation of 29 U.S.C. § 1133(1);

3 e. Failing and refusing to provide an explanation for the  
4 denial of benefits, payments or reimbursements of claims of each of  
5 the Patients, written in a manner calculated to be understood by the  
6 participant, in violation of 29 U.S.C. § 1133(1);

7 f. Failing to afford Plaintiff and/or its Patients with a  
8 reasonable opportunity to engage in an appeals process, in violation of  
9 29 U.S.C. § 1133(2);

10 g. Failing to afford Plaintiff and/or its Patients with a  
11 reasonable opportunity to engage in meaningful appeal process which  
12 was full and fair, in violation of 29 U.S.C. § 1133(2);

13 h. Failing and refusing to provide Plaintiff and/or its Patients  
14 with information pertaining to their rights to appeal, including not  
15 limited to those deadlines for filing appeals and/or the requirements  
16 that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

17 i. Violating the minimum requirements for employee benefit  
18 plans pertaining to claims and benefits by participants and  
19 beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

20 j. Failing and refusing to establish and maintain reasonable  
21 claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

22 k. Establishing, maintaining and enforcing claims  
23 procedures which unduly inhibit the initiation and processing of claims  
24 for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

25 l. Precluding and prohibiting Plaintiff from acting as an  
26 authorized representative of the Patients in pursuing a benefit claim or  
27 appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
28 2560.503-1(b)(4);

1           **m.**     Failing and refusing to design, administer and enforce  
2           their processes, procedures and claims administration to ensure that  
3           their governing plan documents and provisions have been applied  
4           consistently with respect to similarly situated participants, beneficiaries  
5           and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

6           **n.**     Failing and refusing to pay benefits for authorized  
7           services rendered by Plaintiff;

8           **o.**     Failing to offer coverage for mental health and SUD  
9           treatment in parity with the medical and surgical benefits afforded by  
10          the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
11          mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

12          **p.**     Failing and refusing to pay Plaintiff for the SUD  
13          treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

14          **369.**   The failure and refusal of Coventry to provide coverage,  
15          reimbursement, payment and/or benefits for the SUD and/or mental health  
16          treatment benefits rendered by Morningside to Plaintiff's patients who were  
17          covered by Coventry and Coventry's denial of health insurance benefits coverage  
18          constitutes a breach of the insurance plans and/or employee benefit Plans between  
19          BCBS Arkansas and the Patients at issue in this lawsuit.

20          **370.**   Coventry has arbitrarily and capriciously breached the obligations set  
21          forth in the ERISA Plans issued by Coventry and Coventry has arbitrarily and  
22          capriciously breached their obligations under the ERISA Plans to provide Plaintiff  
23          and that as a direct and proximate result of the actions by Defendants, Plaintiff has  
24          been damaged in an amount equal to the amount of benefits Plaintiff should have  
25          received and to which the Patients would have been entitled had Coventry paid the  
26          proper amounts, which Plaintiff estimates to be \$471,554.58.

27          **371.**   As a direct and proximate result of the aforesaid conduct of Coventry  
28          in failing to provide coverage as required, Plaintiff has suffered, and will continue

1 to suffer in the future, damages, plus interest and other economic and  
2 consequential damages, for a total amount Plaintiff estimates to be \$471,554.58, or  
3 as otherwise determined at the time of trial.

4 **372.** Plaintiff is entitled to an award of statutory penalties in the amount to  
5 be determined at the time of trial against Coventry.

6 **373.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
7 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of Coventry,  
8 Plaintiff has retained the services of legal counsel and has necessarily incurred  
9 attorneys' fees and costs in prosecuting this action. Furthermore, Plaintiff  
10 anticipates incurring additional attorneys' fees and costs hereafter pursuing this  
11 action.

12 **TWENTY-FOURTH CLAIM FOR RELIEF**

13 **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

14 **Against HMC)**

15 **374.** Plaintiff realleges and incorporates by reference each and every  
16 paragraph of this Complaint as though set forth herein.

17 **375.** This claim is alleged by Plaintiff for relief in connection with claims  
18 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
19 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §  
20 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
21 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
22 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
23 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

24 **376.** Plaintiff is informed and believes, and based thereon alleges, that  
25 HMC is the insurer, sponsor, and/or financially responsible payer, serve as a  
26 designated plan administrator, and/or services as the named plan administrator's  
27 designee. Plaintiff is further informed and believes, and based thereon alleges, that  
28 with respect to each of the ERISA Plans at issue in this case that are self-insured

1 plans, but which do not specifically designate a plan administrator, HMC  
2 effectively controls the decision whether to honor or deny the a claim under the  
3 ERISA Plans, exercise authority over the resolution of benefits claims, and/or have  
4 responsibility to pay the claims. HMC also plays the role as the *de facto* plan  
5 administrator for such ERISA Plans.

6 **377.** With respect to the ERISA Plans relating to HMC, Plaintiff's claims  
7 against Coventry include 4 patients of Morningside. To date, there remains a  
8 balance due and owing by HMC to Plaintiff in the amount of \$406,572.11.

9 **378.** HMC has not provided Plaintiff with any plan documents, nor has  
10 HMC disclosed to Plaintiff the HMC patients at issue falling under an ERISA Plan  
11 or not, so in an abundance of caution, Plaintiff lists all claims against HMC at this  
12 time. Plaintiff's individual patient claims relating to HMC include the following.

13 **a.** Patient PF, with a balance due and owing to Plaintiff in the  
14 amount of \$23,449.50.

15 **b.** Patient AB, with a balance due and owing to Plaintiff in the  
16 amount of \$180,323.04.

17 **c.** Patient DK, with a balance due and owing to Plaintiff in the  
18 amount of \$148,.757.50.

19 **d.** Patient GL, with a balance due and owing to Plaintiff in the  
20 amount of \$54,042.07.

21 **379.** Plaintiff is informed and believes, and based thereon alleges, that for  
22 each of these claims and for each of the involved Patients, HMC has failed and  
23 refused to pay, process or adjust these claims in an appropriate fashion by, among  
24 other acts and omissions:

25 **a.** Delaying the processing, adjustment and/or payment of  
26 claims for periods of time greater than 45 days after submission of the  
27 claims in violation of 29 C.F.R. § 2560.503-1(f)(2)(iii)(B);  
28

1           **b.**     Failing and refusing to provide any notice and/or  
2           explanation for the denial of benefits, payments or reimbursement of  
3           the claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

4           **c.**     Failing and refusing to provide an adequate notice and/or  
5           explanation for the denial of benefits, payments or reimbursement of  
6           claims of each of the Patients, in violation of 29 U.S.C. § 1133(1);

7           **d.**     Failing and refusing to provide an explanation for the  
8           denial of benefits, payments or reimbursements of claims of each of  
9           the Patients, and by failing and refusing to set forth the specific reasons  
10          for such denials, all in violation of 29 U.S.C. § 1133(1);

11          **e.**     Failing and refusing to provide an explanation for the  
12          denial of benefits, payments or reimbursements of claims of each of  
13          the Patients, written in a manner calculated to be understood by the  
14          participant, in violation of 29 U.S.C. § 1133(1);

15          **f.**     Failing to afford Plaintiff and/or its Patients with a  
16          reasonable opportunity to engage in an appeals process, in violation of  
17          29 U.S.C. § 1133(2);

18          **g.**     Failing to afford Plaintiff and/or its Patients with a  
19          reasonable opportunity to engage in meaningful appeal process which  
20          was full and fair, in violation of 29 U.S.C. § 1133(2);

21          **h.**     Failing and refusing to provide Plaintiff and/or its Patients  
22          with information pertaining to their rights to appeal, including not  
23          limited to those deadlines for filing appeals and/or the requirements  
24          that an appeal be filed, in violation of 29 U.S.C. § 1133(1);

25          **i.**     Violating the minimum requirements for employee benefit  
26          plans pertaining to claims and benefits by participants and  
27          beneficiaries, in violation of 29 C.F.R. § 2560.503-1(a), *et seq.*;

1           **j.**     Failing and refusing to establish and maintain reasonable  
2     claims procedures in violation of 29 C.F.R. § 2560.503-1(b);

3           **k.**     Establishing, maintaining and enforcing claims  
4     procedures which unduly inhibit the initiation and processing of claims  
5     for benefits, in violation of 29 C.F.R. § 2560.503.1(b)(3);

6           **l.**     Precluding and prohibiting Plaintiff from acting as an  
7     authorized representative of the Patients in pursuing a benefit claim or  
8     appeal of an adverse benefit determination, in violation of 29 C.F.R. §  
9     2560.503-1(b)(4);

10          **m.**    Failing and refusing to design, administer and enforce  
11    their processes, procedures and claims administration to ensure that  
12    their governing plan documents and provisions have been applied  
13    consistently with respect to similarly situated participants, beneficiaries  
14    and claimants, in violation of 29 C.F.R. § 2560.503-1(b)(5);

15          **n.**    Failing and refusing to pay benefits for authorized  
16    services rendered by Plaintiff;

17          **o.**    Failing to offer coverage for mental health and SUD  
18    treatment in parity with the medical and surgical benefits afforded by  
19    the same Plan, as required by 26 U.S.C. § 9812(3), as well as other  
20    mandates set forth at 26 U.S.C. § 9812, *et seq.*; and

21          **p.**    Failing and refusing to pay Plaintiff for the SUD  
22    treatments provided to the Patients in violation of 26 U.S.C. § 9812(3).

23       **380.**    The failure and refusal of HMC to provide coverage, reimbursement,  
24    payment and/or benefits for the SUD and/or mental health treatment benefits  
25    rendered by Morningside to Plaintiff's patients who were covered by HMC and  
26    HMC's denial of health insurance benefits coverage constitutes a breach of the  
27    insurance plans and/or employee benefit Plans between HMC and the Patients at  
28    issue in this lawsuit.

1       **381.** HMC has arbitrarily and capriciously breached the obligations set  
2 forth in the ERISA Plans issued by HMC and HMC has arbitrarily and capriciously  
3 breached their obligations under the ERISA Plans to provide Plaintiff and that as a  
4 direct and proximate result of its actions, Plaintiff has been damaged in an amount  
5 equal to the amount of benefits Plaintiff should have received and to which the  
6 Patients would have been entitled had HMC paid the proper amounts, which  
7 Plaintiff estimates to be \$406,572.11.

8       **382.** As a direct and proximate result of the aforesaid conduct of HMC in  
9 failing to provide coverage as required, Plaintiff has suffered, and will continue to  
10 suffer in the future, damages, plus interest and other economic and consequential  
11 damages, for a total amount Plaintiff estimates to be \$406,572.11, or as otherwise  
12 determined at the time of trial.

13       **383.** Plaintiff is entitled to an award of statutory penalties in the amount to  
14 be determined at the time of trial against HMC.

15       **384.** Plaintiff is entitled to an award of reasonable attorneys' fees pursuant  
16 to 29 U.S.C. § 1132(g)(1). As a result of the actions and failings of HMC, Plaintiff  
17 has retained the services of legal counsel and has necessarily incurred attorneys'  
18 fees and costs in prosecuting this action. Furthermore, Plaintiff anticipates  
19 incurring additional attorneys' fees and costs hereafter pursuing this action.

20  
21                               **TWENTY-FIFTH CLAIM FOR RELIEF**

22                   **(Claims for Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)**

23                               **Against GHI)**

24       **385.** Plaintiff realleges and incorporates by reference each and every  
25 paragraph of this Complaint as though set forth herein.

26       **386.** This claim is alleged by Plaintiff for relief in connection with claims  
27 for treatment rendered to members of an ERISA Plan. This claim seeks to recover  
28 benefits, enforce rights and clarify rights to benefits under 29 U.S.C. §



1 1132(a)(1)(B). Plaintiff has standing to pursue these claims as assignee of the  
2 Patients' benefits under the ERISA Plans. As the assignee of benefits under the  
3 ERISA Plans, Plaintiff is a "beneficiary" entitled to collect benefits under the terms  
4 of the ERISA Plans, and is the "claimant" for purposes of ERISA.

5 **387.** Plaintiff is informed and believes, and based thereon alleges, that GHI  
6 is the insurer, sponsor, and/or financially responsible payer, serve as a designated  
7 plan administrator, and/or services as the named plan administrator's designee.  
8 Plaintiff is further informed and believes, and based thereon alleges, that with  
9 respect to each of the ERISA Plans at issue in this case that are self-insured plans,  
10 but which do not specifically designate a plan administrator, GHI effectively  
11 controls the decision whether to honor or deny the a claim under the ERISA Plans,  
12 exercise authority over the resolution of benefits claims, and/or have responsibility  
13 to pay the claims. GHI also plays the role as the *de facto* plan administrator for  
14 such ERISA Plans.

15 **388.** The Clerk of the Court for the Central District of California entered  
16 the default against GHI, the only named defendant in Case No. 8-19-cv-02129.  
17 [ECF No. 343.]

18  
19  
20  
21  
22  
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24 //

25 //

26 //

27 //

28 //

1 **PRAYER FOR RELIEF**

2 **AS TO ALL ERISA CLAIMS FOR RELIEF:**

3 **WHEREFORE**, Plaintiff prays as follows:

- 4 1. For an order that Consolidated Defendants pay to Plaintiff an amount to  
5 be proven at Trial, but no less than \$75,000,000.00;
- 6 2. For economic damages according to proof;
- 7 3. For pre- and post-judgment interest as allowed by law;
- 8 4. For statutory penalties as allowed by law;
- 9 5. For attorney's fees and costs of suit incurred herein; and
- 10 6. For such other and further relief as the Court deems appropriate.

11  
12 Respectfully Submitted,

13 Dated: February 28, 2022

GARNER HEALTH LAW CORPORATION

14  
15 By: Craig B. Garner

16 CRAIG B. GARNER

17 Attorneys for PLAINTIFF ABC SERVICES  
18 GROUP, INC., in its capacity as assignee for  
19 the benefit of creditors of MORNINGSIDE  
20 RECOVERY, LLC

21 SQUIRES, SHERMAN & BIOTEAU, LLP

22 ROCHELLE J. BIOTEAU

23 Attorneys for PLAINTIFF ABC SERVICES  
24 GROUP, INC., in its capacity as assignee for  
25 the benefit of creditors of MORNINGSIDE  
26 RECOVERY, LLC

**CERTIFICATE OF SERVICE**

I hereby certify that on February 28, 2022, I caused the

**CONSOLIDATED AMENDED COMPLAINT FOR BREACH OF  
EMPLOYEE WELFARE BENEFIT PLAN (RECOVERY OF PLAN  
BENEFITS UNDER E.R.I.S.A.) 29 U.S.C. § 1132(a)(1)(b)**

to be served upon counsel in the manner described below:

Participants in the case who are registered CM/ECF users will be served by the Central District CM/ECF system.

***Special Master***

Stephen G Larson  
Larson O'Brien LLP  
555 South Flower Street Suite 4400  
Los Angeles, CA 90071  
213-436-4864  
slarson@larsonobrienlaw.com

***Aetna Health and Life Insurance Company***

Benjamin H. McCoy  
Fox Rothchild LLP  
10 Sentry Parkway, Suite 200  
Blue Bell, PA 19422  
610-397-7972  
bmccoy@foxrothschild.com

John Shaeffer  
Fox Rothschild LLP  
10250 Constellation Boulevard  
Suite 900  
Los Angeles, CA 90067  
310-598-4150

1 ***Anthem Blue Cross Life and Health Insurance Company***  
2 ***Anthem, Inc.***

3 ***Blue Cross of California, Inc.***

4 ***The Anthem Companies of California, Inc.***

5 Steven D Allison  
6 Samrah R Mahmoud  
7 Troutman Sanders LLP  
8 5 Park Plaza Suite 1400  
9 Irvine, CA 92614  
10 949-622-2700  
11 steve.allison@troutman.com  
12 samrah.mahmoud@troutman.com

13 Virginia Bell Flynn  
14 Troutman Sanders LLP  
15 4320 Fairfax Drive  
16 Dallas, TX 75205  
17 804-697-1480  
18 virginia.flynn@troutman.com

19 Chad R Fuller  
20 Troutman Sanders LLP  
21 11682 El Camino Real Suite 400  
22 San Diego, CA 92130  
23 858-509-6000  
24 chad.fuller@troutman.com

25 ***Blue Cross and Blue Shield of Alabama***

26 Neil J Barker  
27 Neil J Barker APC  
28 225 South Lake Avenue Suite 300  
Pasadena, CA 91101  
626-440-5980  
neiljbarker@sbcglobal.net

1 ***Health Care Service Corporation***

2 Amir Shlesinger  
3 Reed Smith LLP  
4 335 South Grand Avenue Suite 2900  
5 Los Angeles, CA 90071-1514  
6 213-457-8000  
7 jgershon@reedsmith.com  
8 ashlesinger@reedsmith.com  
9 ftabibkhoei@reedsmith.com

10 Dan J Hofmeister, Jr  
11 Reed Smith LLP  
12 10 South Wacker Drive Suite 4000  
13 Chicago, IL 60606  
14 312-207-6545  
15 dhofmeister@reedsmith.com

16 ***Blue Cross and Blue Shield of Kansas City***

17 Jonathan Daniel Gershon  
18 Amir Shlesinger  
19 Farah Tabibkhoei  
20 Reed Smith LLP  
21 335 South Grand Avenue Suite 2900  
22 Los Angeles, CA 90071-1514  
23 213-457-8000  
24 jgershon@reedsmith.com  
25 ashlesinger@reedsmith.com  
26 ftabibkhoei@reedsmith.com

27 Dan J Hofmeister, Jr  
28 Reed Smith LLP  
29 10 South Wacker Drive Suite 4000  
30 Chicago, IL 60606  
31 312-207-6545  
32 dhofmeister@reedsmith.com

1 ***Blue Cross and Blue Shield of Kansas Inc***

2 Kimberly Ann Klinsport  
3 Foley and Lardner LLP  
4 555 South Flower Street Suite 3300  
5 Los Angeles, CA 90071-2411  
6 213-972-4500  
7 kklinsport@foley.com

8 Michael A Naranjo  
9 Jason Yon-Wai Wu  
10 Foley and Lardner LLP  
11 555 California Street Suite 1700  
12 San Francisco, CA 94104  
13 415-434-4484  
14 mnaranjo@foley.com  
15 jwu@foley.com

16 ***USable Mutual Insurance Company***

17 Kimberly Ann Klinsport  
18 Foley and Lardner LLP  
19 555 South Flower Street Suite 3300  
20 Los Angeles, CA 90071-2411  
21 213-972-4500  
22 kklinsport@foley.com

23 Michael A Naranjo  
24 Jason Yon-Wai Wu  
25 Foley and Lardner LLP  
26 555 California Street Suite 1700  
27 San Francisco, CA 94104  
28 415-434-4484  
mnaranjo@foley.com  
jwu@foley.com

1 ***Bluecross Blueshield of Tennessee Inc.***

2 Jason Jonathan Kim  
3 Ann Marie Mortimer  
4 Hunton Andrews Kurth LLP  
5 550 South Hope Street Suite 2000  
6 Los Angeles, CA 90071  
7 213-532-2000  
8 kimj@huntonak.com  
9 amortimer@huntonAK.com

10 John B Shely  
11 Bridget B Vick  
12 Hunton Andrews Kurth LLP  
13 600 Travis Street Suite 4200  
14 Houston, TX 77002  
15 713-220-4200  
16 jshely@huntonak.com  
17 bvick@huntonak.com

18  
19 ***Humana Behavioral Health, Inc.***  
20 ***Humana Health Plan of California Inc.***  
21 ***Humana Inc.***  
22 ***Humana Insurance Company***

23 Ronald K Alberts  
24 Norvik Azarian  
25 Gordon Reese Scully Mansukhani LLP  
26 633 West Fifth Street 52nd Floor Los Angeles, CA 90071  
27 213-576-5000  
28 ralberts@grsm.com  
nazarian@grsm.com



1 ***United Behavioral Health***  
2 ***United Healthcare Services Inc.***  
3 ***Optum Services, Inc.***

4 Jennifer S. Romano  
5 Crowell and Moring LLP  
6 3 Park Plaza 20th Floor  
7 Irvine, CA 92614-8505  
8 949-263-8400  
9 dglassman@crowell.com  
10 sphan@crowell.com  
11 jromano@crowell.com

12 ***Cigna HealthCare of California, Inc.***  
13 ***Cigna Behavioral Health of California, Inc.***  
14 ***Cigna Health and Life Insurance Company***

15 Jeanne Louise Detch  
16 Mazda K. Antia  
17 Cooley LLP  
18 4401 Eastgate Mall  
19 San Diego, CA 92121  
20 858-550-6000  
21 jdetch@cooley.com  
22 mantia@cooley.com

23 Matthew D. Caplan  
24 Cooley LLP  
25 1333 2<sup>nd</sup> St. Suite 400  
26 Santa Monica, CA 90401  
27 415-693-2000  
28 mcaplan@cooley.com

1 ***HMC Healthworks, Inc.***

2 Kathleen V. Fisher  
3 Rodney James Jacob  
4 Calvo Fisher and Jacob LLP  
5 535 Pacific Avenue  
6 Suite 201  
7 San Francisco, CA 94133  
8 415-374-8370  
9 kfisher@calvofisher.com  
10 rjacob@calvofisher.com

11 ***Providence Health Plan***

12 Jose Dino Vasquez  
13 Karr Tuttle Campbell  
14 701 5<sup>th</sup> Avenue  
15 Suite 3300  
16 Seattle, WA 98104  
17 206-223-1313  
18 dvasquez@karrtuttle.com

19 Arden J. Olson  
20 Harrang Long Gary Rudnick PC  
21 Oakway Financial Center  
22 497 Oakway Road  
23 Suite 380  
24 Eugene, OR 97401  
25 541-485-0220  
26 Arden.j.olson@harrang.com

27 ***United Medical Resources, Inc.***

28 Dylan Scott Burstein  
Crowell and Moring LLP  
515 South Flower Street 40th Floor  
Los Angeles, CA 90071  
213-622-4750

1  
2 Daniel M Glassman  
3 Stephanie V Phan  
4 Jennifer S. Romano  
5 Crowell and Moring LLP  
6 3 Park Plaza 20th Floor  
7 Irvine, CA 92614-8505  
8 949-263-8400  
9 dglassman@crowell.com  
10 sphan@crowell.com  
11 jromano@crowell.com

12  
13 ***MHNet Specialty Services LLC***

14 Benjamin H. McCoy  
15 Fox Rothchild LLP  
16 10 Sentry Parkway, Suite 200  
17 Blue Bell, PA 19422  
18 610-397-7972  
19 bmccoy@foxrothschild.com

20 John Shaeffer  
21 Fox Rothschild LLP  
22 10250 Constellation Boulevard  
23 Suite 900  
24 Los Angeles, CA 90067  
25 310-598-4150  
26 jshaefter@foxrothschild.com

27 ***Meritain Health, Inc.***

28 Benjamin H. McCoy  
Fox Rothchild LLP  
10 Sentry Parkway, Suite 200  
Blue Bell, PA 19422  
610-397-7972  
bmccoy@foxrothschild.com

1 John Shaeffer  
2 Fox Rothschild LLP  
3 10250 Constellation Boulevard  
4 Suite 900  
5 Los Angeles, CA 90067  
6 310-598-4150  
7 jshaeffer@foxrothschild.com

8 ***First Health Group Corporation***

9 Benjamin H. McCoy  
10 Fox Rothchild LLP  
11 10 Sentry Parkway, Suite 200  
12 Blue Bell, PA 19422  
13 610-397-7972  
14 bmccoy@foxrothschild.com

15 John Shaeffer  
16 Fox Rothschild LLP  
17 10250 Constellation Boulevard  
18 Suite 900  
19 Los Angeles, CA 90067  
20 310-598-4150  
21 jshaeffer@foxrothschild.com

22 Daniel M Glassman  
23 Stephanie V Phan  
24 Jennifer S. Romano  
25 Crowell and Moring LLP  
26 3 Park Plaza 20th Floor  
27 Irvine, CA 92614-8505  
28 949-263-8400  
dglassman@crowell.com  
sphan@crowell.com  
jromano@crowell.com

1 ***Sierra Health and Life Company***

2 Stephanie V Phan

3 Jennifer S. Romano

4 Crowell and Moring LLP

5 3 Park Plaza 20th Floor

6 Irvine, CA 92614-8505

7 949-263-8400

8 dglassman@crowell.com

9 sphan@crowell.com

10 jromano@crowell.com

11 ***Coventry Health Care, Inc.***

12 Benjamin H. McCoy

13 Fox Rothchild LLP

14 10 Sentry Parkway, Suite 200

15 Blue Bell, PA 19422

16 610-397-7972

17 bmccoy@foxrothschild.com

18 ***Medica Health Plans***

19 Elise D. Klein

20 Lewis Brisbois Bisgaard and Smith LLP

21 633 West 5<sup>th</sup> Street

22 Suite 4000

23 Los Angeles, CA 90071

24 213-250-1800

25 Elise.klein@lewisbrisbois.com

26 ***Medical Mutual of Ohio***

27 S. Christopher Yoo

28 Alvaradosmith

1 MacArthur Pl., Suite 200

Santa Ana, CA 92707

714-852-6800

cyoo@alvaradosmith.com

***Beacon Health Options, Inc.***  
***Beacon Health Strategies, LLC***  
***ValueOptions Federal Services, Inc.,***  
***ValueOptions of California, n/k/a Beacon Health Options of California, Inc.***

Henry I. Willett, III  
Christian & Barton LLP  
909 East Main Street, Suite 1200  
Richmond, VA 23219  
804-697-4130  
hwillett@cblaw.com

***Common Ground Healthcare Cooperative***

William D. Naeve  
Murchison & Cumming  
18201 Von Karman Ave.  
Suite 1100  
Irvine, CA 92612  
714-953-2233  
wnaeve@murchisonlaw.com

***Providence Health Plan***

Arden J. Olson  
Harrang Long Gary Rudnick PC  
Oakway Financial Center  
497 Oakway Road  
Suite 380  
Eugene, OR 97401  
541-485-0220  
Arden.j.olson@harrang.com

/s/ Craig B. Garner  
Craig B. Garner  
Counsel for Plaintiff